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ABSTRACT

This final report describes a 5-year Kentucky project to improve integrated educational services and life quality of children and youth with severe disabilities, including students with deaf-blindness. Project objectives focus on the identification and removal of barriers to effective integrated programs; the provision of educational services on age-appropriate regular school campuses; the development of community-based instructional programs; coordinated transition services between preschool and public school programs, and between public school services and adult supports/services in the community; and the development of state-level policies and procedures. By the project's end, a total of 206 students in 22 school districts had moved from segregated to integrated school campuses, and approximately 80 percent of students with severe disabilities in these districts were receiving regularly scheduled community-based instruction. Additionally, the project developed several best practice manuals, a set of personnel preparation competencies and recommendation, and an alternative student assessment and accountability system. Extensive appendices include various meeting and workshop agendas, a teacher's guide to the Alternate Portfolio assessment system, an issue of the Project newsletter, and a manual on students with special health care needs. (DB)

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Kentucky Systems Change Project for Students with Severe Disabilities (1987-1992)

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Final Report

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Kentucky Systems Change Project for Students with Severe Disabilities (1987-1992)

Project Abstract

The Kentucky Systems Change Project for Students with Severe Disabilities was a five year project, funded through the United States Office of Special Education Programs to the Kentucky Department of Education. The project was administered through the Interdisciplinary Human Development Institute of the University of Kentucky.

The project goal was the improvement of integrated educational services and the enhancement of the quality of life of children and youth with severe disabilities, including students with deaf-blindness, in Kentucky. Project objectives focused on the identification and removal of barriers to effective, integrated programs; the provision of educational services on age-appropriate regular school campuses; the development of community-based instructional programs; coordinated transition services between preschool and public school programs, and between public school services and adult supports/services in the community; and the development of state-level policies and procedures to promote integrated programs and increased funding/program options.

The project worked with a total of 22 school districts in improving integrated, community-based instructional programs to children and youth with severe disabilities. At the end of the project's fifth year, a total of approximately 206 students had moved from segregated to integrated school campuses in participating districts, and approximately 80% of students with severe disabilities in these districts were receiving regularly scheduled community-based instruction.

At the state level, the project developed a number of best practice manuals that were disseminated by the Kentucky Department of Education to administrators and teachers state-wide. These products included *Considerations in Extended School Year Services for Students with Severe Handicaps, Integrating Related Services into Programs for Students with Severe and Multiple Handicaps, Services for Students with Special Health Care Needs, the Model Local Catalogs and Curriculum Process for Students with Moderate and Severe Handicaps, Communication Programming for Students with Severe and Multiple Handicaps, and the Quality Program Indicators for Students with Moderate and Severe Handicaps.*

In addition the project facilitated, in collaboration with Kentucky's Institutes of Higher Education, the development of Proposed Preservice Competencies and Personnel Preparation Recommendations for teachers of students with moderate and severe disabilities. The project also worked closely with the Kentucky Department of Education in the development of the Alternate Portfolio Assessment and Accountability System for students

with significant disabilities, so that students with severe disabilities would be fully included in Kentucky's assessment and accountability assessment system for all students.

Note: A copy of the enclosed Final Report has been sent to ERIC.

KENTUCKY SYSTEMS CHANGE PROJECT

Year Five Final Report

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KENTUCKY SYSTEM CHANGE PROJECT FOR STUDENTS WITH SEVERE DISABILITIES

Final Project Report

Introduction

The following report and associated appended materials summarize the major accomplishments and activities of the Kentucky Systems Change Project (Grant Number G0087C3061, Project Number 0865470010) for the duration of the project (October 1, 1987 - September 30, 1992). Previous progress and activities for the project were reported in the Year I, Year II, Year III, and Year IV Final Reports, and in the December 1991 and March 1992 Quarterly Progress Reports.

This report is organized into two sections. **Section I** describes the major project accomplishments *by objective* over the *entire five year course* of the project. **Section II** describes in detail the accomplishments *by task* of the *current reporting period* (the final six months of the project, April 1, 1992 - Sept. 30, 1992). The project's Year V data report is included in this second section.

Section I
Kentucky Systems Change Project
Accomplishments by Objective

This section of the Year V Final Report briefly summarizes project accomplishments under each of the fifteen objectives identified in the original Systems Change proposal. This part of the Year V report thus highlights major accomplishments over the entire course of the project.

Objective 1. To coordinate all project activities with existing efforts being made in the state on behalf of individuals with severe handicaps and individuals who are deaf-blind.

The project has worked closely with all existing state efforts in programs and services for children and youth with severe disabilities. Examples of this coordinated effort include:

- The project coordinates all training activities (Summer Institute, Annual Faculty Seminar for Kentucky IHEs, consultations in local districts) with staff of the Kentucky Deaf-Blind Intervention Project. This project is the designated 6C agency for children and youth with deaf-blindness in Kentucky.
- Project staff have lead responsibility for the Kentucky Department of Education's state-wide teacher inservice training program for teachers

of students with moderate and severe disabilities (SPLASH: Strategies for Programming Longitudinally for all Students with Severe Disabilities) and provide classroom follow-ups (site visits) to teachers throughout the state who are receiving SPLASH training. The in-service component of SPLASH consists of 80 hours of instruction for teachers in best practice implementation for students with severe disabilities. The project has functioned in this capacity over the entire five years of the Systems Change Project.

- The project has developed several key guideline papers and manuals for the Kentucky Department of Education, including *Considerations in Extended School Year Services for Students with Severe Handicaps, Integrating Related Services into Programs for Students with Severe and Multiple Handicaps, Services for Students with Special Health Care Needs, the Model Local Catalogs and Curriculum Process for Students with Moderate and Severe Handicaps, Communication Programming for Students with Severe and Multiple Handicaps, and the Quality Program Indicators for Students with Moderate and Severe Handicaps.*

- The project played a key role in facilitating the development of the Kentucky Executive Transition Task Force, which includes the heads of all agencies with responsibilities for transition services to youth with disabilities in Kentucky. The project continues to insure that the needs of students with severe disabilities are represented in the workscope of the Executive Task Force. Project staff were instrumental in the writing of the Executive Interagency Transition Agreement and the development of the Task Force's training manual, which has been used by the KDE in training every local school district in the state.

Objective 2. To identify barriers to services at the state and local community levels.

The project has systematically identified major barriers to exemplary service delivery for students with severe disabilities throughout the duration of the five years. Activities under this objective have included:

- In Year I, the project conducted Key Informant Interviews with major state agency representatives and administrators having responsibilities for services to children and youth with severe disabilities. The project analyzed and reported this data to the KDE, and included it in the Year I Final Report.

- In Year II, the project conducted a survey with nearly 100 speech and hearing therapists providing services to students with severe disabilities in local public schools to determine the current status of these services in Kentucky, and the extent to which speech/language pathologists are cognizant of best practices in this area. This information was used to provide state-wide training during Year II for speech-language pathologists serving students with severe disabilities and to develop the project's Communication Programming Manual.

- In Year II, the project coordinated its barrier identification efforts with the California Research Institute to determine administrator, teacher, and parent perceptions of educational programs in separate and integrated school settings, and to determine their perceptions of major barriers to the provision of integrated, community-based programs.

- In Year IV, the project conducted a state-wide survey of all teachers of students with moderate and severe disabilities to determine the extent to which students with complex health care needs were served in public school settings (including separate schools and regular campuses) and to determine who was responsible for the provision of health related services to these students. The results of this survey were included in the June 1991 Quarterly Report, and were used in the development of the project's Health Care Needs Manual.

- In Year V, in conjunction with the Kentucky Deaf-Blind Intervention Project and the University of Kentucky Department of Special Education, the project conducted a similar survey of local special education coordinators. The results of this survey were included in the December, 1991 Quarterly Report.

The results of all of the above surveys are provided to the Kentucky Department of Education and are available to local school districts.

Objective 3. To provide technical assistance and other appropriate support to LEAs and other community service providers in the provision of quality programs in integrated settings.

The major focus of project efforts have focused on the provision of on-site technical assistance to local districts in the development of exemplary, integrated programs. Over 600 days of on-site assistance have been provided by the project to local districts throughout the state. Comprehensive data for each of these districts have been reported on a yearly basis; these data include the number of students with the most severe disabilities being served in age-appropriate regular school settings, the number of students attending regular classes, the number receiving regularly scheduled community-based instruction, the number receiving health related procedures at school, the number in buddy or peer tutor programs, etc. A total of 22 local districts have participated as project districts, including nearly all of the state's largest districts, as well as a wide range of more rural districts throughout Kentucky. On-site technical assistance has been provided to teachers, related service and paraprofessional staff, school site and central office administrators, and to community agency personnel providing services to students with severe disabilities. On-site assistance has taken several forms, including:

- The establishment and facilitation of District Wide and School-Based Integration Task Forces, for the purposes of developing more inclusive school programs for students with severe disabilities.
- Within-district and cross-district teacher work groups for program planning and development. The project's *Quality Program Indicators for Students with Moderate and Severe Handicaps* has served as a program planning and program review guide for both teachers and administrators.
- Visitation to exemplary project sites with local district personnel who are attempting to develop similar programs.
- The use of project consultants with specific areas of expertise (technological applications, communication development for students with the most severe disabilities, etc.) in participating districts.
- Within-district training sessions on specific programming areas (embedding basic skills in community-referenced activities, etc.)
- Hands-on and direct modeling of instructional procedures for students with severe disabilities in school and community settings.

Objective 4. To establish model strategies for the identification (and overcoming) of barriers for dissemination and application across the state.

As reported under Objective 2, the project has systematically identified barriers to exemplary, integrated programs for students with severe disabilities, and has developed specific training and consultation strategies to overcome those barriers. Examples of accomplishments under this objective include:

- State-wide training to speech/language pathologists serving students with severe disabilities. The project conducted a series of five two-day trainings in the provision of consultative and direct services to students with the most severe disabilities (with direct classroom follow-up to speech/language pathologists serving students in participating project districts) and produced the nationally disseminated manual *Communication Programming for Students with Severe and Multiple Handicaps*, which has been subsequently distributed by the KDE.
- Development of the *Integrating Related Services into Programs for Students with Severe Disabilities Manual*, and school team trainings focusing on the implementation of the transdisciplinary service delivery model.

- In response to documented state-wide need for best practice information in the provision of integrated services to children with complex health care needs, the development of the manual *Services to Children with Special Health Care Needs* for state-wide dissemination and training by the KDE. The project worked extensively with local district school nurses, school administrators, and the Kentucky Board of Nursing in the development of this manual. A key component of this 'systems change' effort was extensive advocacy by Systems Change Project Advisory Board members with the Kentucky Board of Nursing to gain Board of Nursing support for the provision of health related procedures in the least restrictive, least intrusive manner possible in public school settings. The final version of the manual is provided in Appendix G.

Objective 5. To increase the use of community-referenced instruction throughout the state.

A major focus of the project's on-site technical assistance to local districts has been in the development of strategies to implement effective community based instruction for students with the most severe disabilities. At the end of the first project year, only 34% of students with the most severe disabilities in participating project districts were receiving regularly scheduled community-based instruction. At the end of Year V, that percentage had increased to 79.1% of these students for Year I districts, and to 80.7% for all participating project districts. It is important to note that, in determining these percentages, the project did *not* include those students with more moderate disabilities, who in most cases received community-referenced instruction before students with the most severe disabilities were included. Other strategies used by the project included:

- The provision of state-wide SPLASH training for the KDE over the past four years to 175 teachers statewide, including a three-day training module on community-based instruction for all participants, with hands-on training in developing and implementing actual CBI programs for students with severe disabilities.

- The provision of Summer Institute sessions focusing on community-based instruction for students with severe disabilities, and specific adaptations for participation for students with the most severe and multiple disabilities.

- The development of the project's *Quality Program Indicators Manual for Students with Moderate and Severe Handicaps*, which includes a major section on the development of community-based instruction, and standards for reviewing the effective provision of community-based services. This manual was disseminated by the KDE to every teacher of students with moderate and severe disabilities in the state.

- The KDE's dissemination of the project's *Model Local Catalogs and Curriculum Process for Students with Moderate and Severe Disabilities* to all teachers and local district special education coordinators throughout the state. This curriculum process uses the activity catalog approach to prioritize home, school, and community activities with the student and his family.

Objective 6. To provide systematic transition planning for children and youth and their parents at every transition point.

The project has focused on transition issues in a variety of ways. As indicated in Objective 1, the project played an instrumental role in the development of the Kentucky Executive Transition Task Force, and its subsequent considerations for students with the most severe disabilities. At the local district level, activities have included:

- Assistance in the movement of students from age-inappropriate settings (e.g., secondary age students with severe disabilities served in an elementary school) to age-appropriate regular school settings. At the end of Year V, the percentage of students served in age-appropriate regular school buildings in participating districts had increased from to 29.6% to 84.2% for Year I districts and to 86.5% for participating project districts as a whole. Moreover, these data *underestimate* the actual movement, because these data do *not* reflect the movement of students from Somerset Education Center (a segregated facility in a participating project district) to age-appropriate regular schools in the Fall of 1992.

- Assistance to teacher workgroups in participating districts in the development of transition procedures for students moving from elementary to middle and from middle to high school programs, including the systematic transferral of information on integrated classes and community-based instruction for each student.

- In Year V, the extensive preparation of primary school building site teams for the inclusion of students with severe disabilities into the Kentucky regular primary school model. In several instances, this training included staff from integrated preschool or kindergarten programs transitioning students with severe disabilities to inclusive primary programs.

Objective 7. To facilitate the movement of students in segregated settings into integrated public school settings and community living arrangements.

One of the key criteria for the initial selection of participating project districts was the existence of a separate school facility for students with severe disabilities in applicant districts. The project worked with separate school programs in six local districts: five of those separate school facilities are now closed. The project facilitiated the movement of approximately 206 students from segregated to regular campus placements. With the beginning of the 1992-1993 school year, only four LEA-operated separate school programs for students with severe disabilities continue to operate in the state.

A related activity has been the development in Year V of four fully-inclusive primary school sites in project sites. Inclusive education programs are presently planned for 12 participating project school sites for the 1992-1993 school year.

Objective 8. To provide training to local decision-makers, including school superintendents, directors of special education, principals, vocational rehabilitation counselors, human service agency personnel, and other community leaders.

The project has made this objective a focus in all of its efforts. Examples of activities under objective 8 include:

- Two two-day "Principals Workshops" on best practices for students with severe disabilities in March and July of 1989. These workshops were open to all building level principals serving students with moderate and severe handicaps in Kentucky.
- Representation of building level and central office administrators on District Wide Integration Task Forces in Kenton County, Fayette County, Somerset, Paducah, and Jessmine County.
- Representation of building level and central office administrators in Summer Institute trainings.
- Representation of building level administrators in school site team trainings focusing on inclusive education. During Years IV and V, the project has provided eight school site team trainings.
- An administrative issues one-day training for building level and central office administrators each year in the KDE SPLASH training provided by the project.

Objective 9. To identify and recommend necessary changes in state law and/or regulations to facilitate the goals of the project.

The project has focused its efforts for this objective by developing policy and guideline papers for the KDE that address how local districts can best implement integrated programs for students with severe disabilities within the context of existing state and federal regulations. Examples of this include:

- Development for the KDE of a guidelines/consideration paper in implementing integrated extended school year services for students with severe disabilities.

- Development for the KDE of an age-appropriate guidelines paper for the placement of all students in regular age-appropriate school years.

- Technical assistance to the Kentucky Executive Transition Task Force in its development of an exemplary transition model, for use by local districts in implementing the Individuals with Disabilities Education Act (IDEA).

- Specific position statements and recommendations by the Project Advisory Board to the Kentucky Cabinet for Human Resources in respect to the development of community-based residential supports for persons with severe disabilities and the movement away from facility-based residential settings.

- The development of a best practice manual on guidelines for students with special health care needs in regular school settings, developed in conjunction with local school providers, and with the input and endorsement of the Kentucky Board of Nursing

- Technical assistance and advocacy efforts by the project to the KDE in the philosophy and implementation of a Kentucky primary school model that is truly inclusive of all students, via a state-wide training proposal and presentation to the Kentucky Primary School Implementation Task Force.

- Technical assistance to the Kentucky Disability and Diversity Subcommittee on Student Assessment in the development of KDE policy for an alternative portfolio system for students with moderate and severe disabilities. This Alternate Portfolio will carry full weight in determining school effectiveness and school rewards and sanctions under KERA. Project assistance was instrumental in the development of this policy.

  Moreover, project staff have been the lead authors in the development of the Alternate Portfolio itself and have insured that the portfolio *standards* are keyed to evidences of interactions and friendships with nondisabled peers, performance across multiple regular school and community settings, and the development of informal support systems allowing for participation of students with the most severe disabilities. See Section II of this Report and Appendix D for a more detailed description of the Alternate Portfolio.

- The development of major teacher certification reforms in the area of Low Incidence Disabilities through the project's Higher Education Subcommittee of the project Advisory Board. This subcommittee, consisting of teacher trainers from major state institutions and local service providers, has prepared these recommendations for the

Kentucky Education Professional Standards Board (see Appendix A). The Kentucky Department of Education has incorporated the Subcommittee's recommendations in its own report of recommended changes to the Professional Standards Board.

Objective 10. To establish linkages and relationships with employers/ community businesses regarding employment opportunities and options.

The project has accomplished this objective in several major ways:

- Provision of direct technical assistance to local districts in the development of community-based vocational training programs for students with severe disabilities. In a number of instances, technical assistance included training and on-site assistance to the district's community-based vocational trainer and/or secondary-level teachers, actual assistance to districts in contacting and negotiating with local businesses for placement of students, and planning sessions with vocational rehabilitation counselors and adult service providers in those local districts.

- Technical assistance to the Kentucky Executive Transition Task Force in the development of the Kentucky Transition Model, with its emphasis upon community-based vocational assessment, training, and placement for students with severe disabilities.

- Training in this area through the project's Summer Institute for teachers and administrators, and through the project's provision of KDE SPLASH training.

- Conference presentations with participating local districts who are implementing community-based vocational training with students with severe disabilities.

Objective 11. To facilitate the coordination between preschool programs and public school programs.

The project has accomplished this objective through the following activities:

- Extensive project staff involvement in conducting training sessions for the Kentucky Department of Education's SHIPP training (Serving Students with Handicaps in Integrated Preschool Programs). This training has focused on the inclusion of students with severe and multiple disabilities.

- As reported under Objective 6, the preparation of primary school building site teams for the inclusion of students with severe disabilities into the Kentucky regular primary school model. In several instances, this training included staff from integrated preschool or kindergarten programs transitioning students with severe disabilities to inclusive primary programs.

- Sustained technical assistance to one local district in closing its separate school program for students with moderate and severe disabilities and its subsequent placement of a model integrated preschool program at that site.

- Successful negotiations with the Kentucky Department of Education to fund a series of eight regional trainings to develop inclusive primary school teams in the 1992-1993 school year (after the expiration of the present project). Each of these building and district level teams will include a representative from a sending preschool program in that district.

Objective 12. To establish a greater working relationship between adult service providers and public schools.

Activities accomplished under this objective include:

- As noted above, facilitation of the Kentucky Executive Transition Task Force, which includes the state directors of all major agencies providing services to adults with disabilities, including adults with severe disabilities.

- Direct assistance to local project districts in developing cooperative programs with vocational rehabilitation services and adult service agencies in providing community-based vocational training and supportive employment placements for students with severe disabilities.

- Training to 175 teachers throughout Kentucky via SPLASH in developing greater working relationships with adult service providers.

Objective 13. To increase options/funding mechanisms for implementing increased program options.

This objective has been addressed through the following activities:

- Technical assistance and fiscal support to the Kentucky Transition Task Force in developing regional state-wide training to all school systems and adult service providers in transition services. This training has been financed through the shared resources of the participating agencies.

- Local district guideline papers prepared by the KDE for the implementation of integrated extended school year services and for age-appropriate placement of all students in the context of neighborhood schools.

- Technical assistance to participating project districts in the development of successful applications for participation in the Kentucky School to Community Work Transition Program, funded through the Kentucky Office of Vocational Rehabilitation.

- As indicated under Objective 11, successful negotiations with the Kentucky Department of Education to fund a series of eight regional trainings to develop inclusive primary school teams in the 1992-1993 school year (after the expiration of the present project). Each of these building and district level teams will focus on the inclusion of all students, including students with severe disabilities, in the ungraded primary program mandated for each of Kentucky's regular elementary schools.

Objective 14. To develop a set of statewide strategies that assure there is no reduction in service because of movement to less restrictive environments.

State-wide strategies implemented under this objective include:

- The establishment of District Wide Integration Task Forces, including central office administrators, principals, teachers, parents, related services staff, and paraprofessionals in participating districts operating segregated school programs, with the expressed intent of insuring that students continue to receive all needed services with their movement to regular school campuses.

- The provision of eight school site team trainings in Years IV and V, to insure that school sites continue to provide all needed supports to students with severe disabilities as these students are included in the regular primary program, and become regular members of elementary, middle school, and high school classes. A major provision of this training has been on-site assistance to school site teams in the implementation of their action plans.

- Statewide dissemination by the KDE to all teachers of students with moderate and severe disabilities and to all local special education coordinators in the state of the project's *Quality Program Indicator Manual*, which details best practices across six programming components for students served in integrated settings.

- Continued, yearly follow-ups in participating local districts of students moved from segregated to integrated school settings, to insure that there is no reduction in instruction or supports for these students.

- Development and dissemination of the project's *Integrating Related Services into Programs for Students with Severe and Multiple Handicaps Manual*, which details specific components of and strategies for implementation of a transdisciplinary service model in integrated settings. The project has provided numerous training sessions to building level teams in participating local districts in the implementation of this model.

Objective 15. To develop public awareness and educational materials and procedures as a component of comprehensive program development to sensitize the community to positive social integration and employment potential and to reduce parental fears of social rejection.

Activities under this objective include:

- Statewide and national dissemination of all project products, including dissemination without charge to all parents of children and youth with severe disabilities who request project products. Products are made available to participating districts and Kentucky Institutes of Higher Education also without charge, and to all others for the cost of duplicating and postage.
- Numerous local newspaper articles describing integrated educational programs in project sites throughout the state, and project press releases on exemplary programs to local newspapers.
- The development of a video on Wheelchair Safety for regular education students, which has been shown on public television.
- The extensive revision of Kentucky's *High School Peer Tutoring Manual*, which enables regular high school students to work as peer tutors in high school programs for students with severe disabilities, and which includes informational and experiental modules on such topics as Friendships and Relationships, Legal Rights, Families of Persons with Disabilities, Community Services, Integration and Inclusion, developed by project staff. This course is presently being offered to regular high school students in 30 local school districts.
- Facilitation of individual student MAPS and Circles of Friends, always developed with the full participation of the family, for students with severe disabilities in participating project districts.
- Numerous state, national, and international presentations to parents and professionals in the development of best practices for students with severe disabilities.
- Statewide dissemination of the project newsletter, focusing on inclusive education programs for students with severe disabilities (a copy of the newsletter in included in Appendix F)

Section II

Summary of Project Activities by Task: April 1, 1992 - September 30, 1992 and Final Project Evaluation Data

The second section of this report focuses on the activities of the *current* reporting period (April 1, 1992 - September 30, 1992). These activities are reported by *task*, so as to be consistent with the format of all previous progress reports of the project.

TASK 1.0: To Establish a Project Advisory Board

The project advisory board continued to function as described in the original proposal. Membership on the advisory board represents: state-level personnel responsible for programs and services for children and youth with severe handicaps, including those who are deaf-blind; local program administrators, teachers, and related service personnel; university training personnel; parents; and representatives of consumer and advocate groups.

Two meetings of the advisory board was conducted during this reporting period. These meetings were held on April 29, 1992 and July 22, 1992. The agenda and minutes for these meetings are included in Appendix A, as well as the advisory board members' evaluation of their own participation on the board. The Advisory Board identified pre-service issues in higher education teacher preparation programs as the highest priority area for advisory board involvement for the final project year. To this end, the Advisory Board formed a Higher Education Subcommittee. This Subcommittee, including five low incidence faculty members from representative Kentucky universities, developed a set of broad recommendations for changes in teacher education reflecting current best practice. These recommendations also included a set of proposed teacher competencies. The final recommendations and proposed teacher competencies of this Subcommittee, addressed to the Kentucky Education Profession Standards Board, are also included in Appendix A. These recommendations, made in collaboration with staff of the Kentucky Office of Teacher Education and Certification, will be brought before the Professional Standards Board in October.

In addition, five members of the project's Advisory Board were very instrumental (through their direct testimony before the Kentucky Board of Nursing) in securing the full endorsement of the Nursing Board for the project's *Services for Children with Special Health Care Needs Manual*. The support of the Board of Nursing, which is the regulatory body for all of Kentucky's nurses, was essential to ensure that health related procedures for students with severe disabilities are provided in the least restrictive, least intrusive manner possible. A final copy of this manual is included in Appendix G.

TASK 2.0: To identify barriers to service provision through the use of "Key Informant Interviews" at the state and local levels.

As indicated above, the Advisory Board identified pre-service issues as a key barrier in the provision of high quality, integrated services. As a result, the board named the Higher Education Subcommittee, consisting of five Low Incidence faculty members from Kentucky universities, Special Education Departmental Chairs from those universities, two local special education directors, one building level principal, the Director of the Kentucky Deaf-Blind Intervention Project, Kentucky Systems Change Project staff, and the Director of the Kentucky Department of Education Division of Teacher Certification Programs.

Specific barriers at the pre-service level identified by this Subcommittee and addressed in its final recommendations to the Kentucky Education Profession Standards Board included:

- Insufficient numbers of teachers certified in TMH (Trainable Mental Handicaps) and SPH (Severe and Profound Handicaps), as evidenced by increasing numbers of Emergency Certified teachers in Kentucky in these areas

- Insufficient coursework specific to Low Incidence Disabilities (i.e., 12 hours including student teaching) within the present TMH certificate requirements

- Present competencies identified for state certification in TMH and SPH do not reflect the Kentucky Program of Study requirements for students with moderate and severe disabilities *or* current best practices

- Regular education teachers certified in Secondary Education cannot obtain TMH certification without first obtaining an a Regular Elementary Certificate, which has resulted in a reduction of available candidates for TMH certification

- Given current best practices of students attending their neighborhood schools in the context of regular homeroom and class membership, current certification requirements do not reflect the extensive need for collaborative and inclusive education skills

- Given the heterogeneity of students assigned to age-appropriate regular school campuses, and especially to neighborhood schools, the current distinction between a TMH and a SPH certificate in Kentucky does not reflect the programming needs of all students

Again, Appendix A contains the full text of the Subcommittee's recommendations for addressing these teacher preservice barriers.

TASK 3.0 Design a Technical Assistance System for Local Communities

The primary form of technical assistance to local districts continues to be provided on site. Project staff provided a total of 35.75 days of on-site technical assistance and consultation to project local districts during the present reporting period, including 2.0 days on-site assistance by project consultants. In addition, project staff provided four SPLASH on-site teacher consultations to other programs for students with moderate and severe disabilities throughout the state.

Specific examples of project technical assistance activities are presented below for each of the participating LEAs, along with the total number of on-site technical assistance days to each LEA provided by project staff and project consultants for this reporting period.

Bell County: No on-site days were provided during the Final Reporting Period, though Bell County teachers did participate in the May cross-district teacher work group.

Bullitt County: No on-site days provided during this final reporting period.

Carroll County: 1.5 days on-site assistance for Circle of Friends activity, consultation on inclusion, and year-end data collection.

Christian County: 1.0 days for on-site data collection; a team from Christian County also participated in the Western Kentucky Integrated Therapy Training for participating districts.

Covington Independent: 4.5 days on-site technical assistance in developing students' MAPS, developing skills/activity matrices, year-end data collection, administrative and principal meeting on neighborhood schools, and a faculty inservice on developing inclusive primary school programs for one elementary school.

Elizabethtown Independent: No one site days this reporting period.

Fayette County: 1.75 days on year-end data collection and classroom consultations.

Hopkins County: 1.0 inclusive primary program workshop; a team from Hopkins County also participated in the Western Kentucky Integrated Therapy Training for participating districts.

Jefferson County: 7.0 days for administrative meeting on neighborhood schools, planning for SAFAK training, consultations to school sites in integrated therapy (includes 2.0 consultant days), and leader and teacher training on the Alternate Portfolio.

Jenkins Independent: 1.5 days consultation on interagency transition and district participated in cross-district work group (hosted in Jenkins).

Jessamine County: 3.5 days on teacher support network, student MAPS planning, classroom consultations and year-end data collection, and district neighborhood school planning.

Kenton County: 4.5 days on-site administrative planning meeting for neighborhood schools and year-end data collection, and SAFAK training for two elementary school faculties.

Knott County: No on-site days, but participated in eastern Kentucky cross-district work group.

Newport Independent: 2.0 days on developing student MAPS and year-end data collection.

Oldham County: .5 days classroom consultations on developing inclusive activities for an elementary student.

Somerset Independent: 6.0 days assistance in district planning and staff participation in State Level Planning Task Force for Oakwood students, SPLASH training (two days) for regular and special education staff, and year-end data collection.

Warren County: 1.0 days on year-end data collection.

In addition to the above activities in project districts, project staff provided four (4) on-site follow-up visits throughout Kentucky to teachers participating in SPLASH (Strategies for Programming Longitudinally for All Students with Severe Handicaps) during this reporting period. SPLASH is the Kentucky Department of Education's state-wide inservice training for teachers of students with moderate and severe disabilities. Each teacher's follow-up consultation focused on an Action Plan developed in conjunction with the teacher's Special Education Coordinator and Building Principal. Each Action Plan addressed two of the six components of the Systems Change Project's *Quality Program Indicators for Students with Moderate and Severe Handicaps.*

Project staff also provided 2.0 days on-site assistance to four other Kentucky school districts in the following areas: inclusive education programs, a student MAPS session, transition planning, and age-appropriate programming.

During this reporting period, the project provided the following trainings for participating local districts:

- *Schools are For All Kids Level II* Training for school site teams from Covington Independent Schools (2 day training, June 10th and 11th for 25 participants).
- SPLASH training on communication and vocational training, integration and peer support strategies to approximately 40 participants in Somerset April 14th and 15th.
- Western Kentucky Integrated Therapy Workshop for teams of teachers and related service personnel from participating western Kentucky districts (one day).
- Alternate Portfolio Implementation training (full day) to the Jefferson County Alternate Portfolio Regional Leaders and to approximately 160 Jefferson teachers and administrators.

The agendas and evaluation summaries for the above trainings are included in Appendix B. In addition, project staff coordinated a neighborhood school planning workshop (one day), conducted by Dr. John McDonnell, for participating project sites in June. This training was attended by 50 teachers and administrators. The project also co-sponsored the Annual Five Day Summer Institute with the Kentucky Deaf-Blind Intervention Project in July. Seventy participants attended the overview (first) day of training for the Summer Institute and fifteen attended the full week. The agendas and evaluation summaries for these two trainings are included in Appendix B as well.

Finally, a summary of student change data for each project district is included under Task 6.0 for districts selected from Years I through IV. Accomplishments for districts selected for Year V are included in Appendix C.

TASK 4.0: Dissemination of Model Strategies, Materials, and Programs

Activities under task 4.0 during the present reporting period included dissemination of several major project products: *Integrating Related Services for Students with Severe and Multiple Handicaps; The Model Local Catalogs and Curriculum Process for Students with Moderate and Severe Handicaps;* and *The Quality Program Indicators Manual for Students with Moderate and Severe Handicaps.* The project continues to disseminate all of these products nationally for the cost of duplication and postage and is maintaining a data base on persons who request these materials.

Additional dissemination activities during this reporting period included the following presentations to:

- The Kentucky Primary School Implementation Task Force on developing inclusive primary school programs, Frankfort, April, 1992.

- Graduate and undergraduate course at Eastern Kentucky University on secondary and vocational opportunities for students with severe disabilities, Richmond, April, 1992.

TASK 5.0: Providing training for local decision-makers such as superintendents, directors of special education, principals, vocational rehabilitation counselors, and adult service providers.

The most critical activity under TASK 5.0 is the Systems Change Project's lead role in the development of the Kentucky Alternate Portfolio Assessment System for students with moderate and severe disabilities. As reported in the March, 1992 Report, the Alternate Portfolio System is designed to meaningfully assess the educational outcomes of students who, even with adaptations and program modifications, are unable to participate in the regular performance-based assessment system (the majority of students in the alternate system will be students with moderate, severe, or multiple disabilities). This state-wide alternate system will carry full and equal weight with the regular assessment system in determining each school's and district's educational success, and student results in the Alternate Portfolio will be fully included in determining school rewards and sanctions under the landmark Kentucky Education Reform Act (KERA) of 1990.

Under the advisement and guidance of the Kentucky Assessment Subcommitttee on Disability and Diversity and the Kentucky Alternate Portfolio Advisory Committee, the Systems Change Project has accomplished the following activities during this reporting period:

- Met with staff from the Kentucky Department of Education and Advanced Systems in Measurement and Evaluation, Inc. (the KDE Contractor for development of comprehensive state-wide performance-based testing) to draw up a plan for the development and implementation of the Alternate Portfolio System.

- As a direct part of this plan, conducted a three day meeting of the Alternate Portfolio Advisory Committee to develop the framework and general structure of the Alternate Portfolio System. This Advisory Committee was made up of teachers, local administrators, university faculty, and staff from the KDE, Advanced Systems, Inc, and the Systems Change Project. The agenda and the minutes of this meeting are included in Appendix E. Project staff developed the resource materials and activities for this meeting, and acted as meeting facilitators. Project staff further conducted a one-day follow-up meeting for the Advisory Committee in August. The agenda and proceedings of the August meeting are included in Appendix E as well.

- Developed the *Teachers Guide for the Alternate Portfolio* (Appendix D). This guide contains descriptions of each of the required and optional portfolio entries, samples of activities and entries for each of the accountability points (4th, 8th, and 12th grade levels), and the Standards and Scoring Guide. As a direct part of the standards, exemplary portfolios will have to evidence high levels of interactions and friendships with nondisabled peers, performance across multiple regular school and community settings, opportunities for student choice, planning and initiation of activities, and assessment of the natural supports in place for students with the most severe disabilities.

- Provided a full day training to the Alternate Portfolio Regional Leaders, a group of master teachers and university personnel representing all areas of the state. Regional leaders will provide information and training on the Alternate Portfolio to local district teachers and administrators throughout Kentucky during the 1992-1993 school year. The agenda and evaluation summary for this training are included in Appendix E.

- Provided a separate full day training to the Jefferson County (Louisville) Regional Leaders and a subsequent full-day training to approximately 160 Jefferson County teachers and administrators on the implementation of the Alternate Portfolio.

Additional activities specific to this task during this reporting period include the following:

- Continued facilitation of the Kentucky Executive Transition Task Force, a state-level group composed of the heads of the Office of Education for Exceptional Children, Office of Vocational Rehabilitation, Office of Instruction, and Office of Adult Education from the Department of Education; Department of Mental Health/Mental Retardation Services, Department of Social Services, and Department of Manpower Services in the Cabinet for Human Resources; and Department for the Blind. Systems Change Project staff have played a major role in the development of a State-Level Interagency Agreement on Transition Services, and accompanying manual The Kentucky Model for Interagency Individual Transition Planning for Students with Disabilities. The project co-sponsored the June and September 1992 meetings of the Kentucky Executive Transition Task Force.

- Inclusion of building level principals and other district administrators in the *Schools Are For All Kids Level II* Trainings.

- Facilitation of middle-school panel on integration for students with severe disabilities for the combined administrative staffs of Somerset

City and the Pulaski County Schools.

- Inclusion of Special Education Departmental Chairs from participating Institutes of Higher Education in the Higher Education Subcommittee.
- Presentation to the Kentucky Department of Education Leadership Team on inclusive primary school training under KERA.
- Neighborhood school planning meetings with the administrative staffs of four local school districts.
- Development of a module on "Systems Change" within the context of the Kentucky Education Reform Act of 1990 for the University of Kentucky Institute on Education Reform. This module will be used for training regular education administrators and teachers.

The target audiences represented in task 5.0 are provided continued technical assistance at each participating site through local district administrative planning and participation on school-based site teams.

TASK 6.0: Evaluation of all Project Activities

Project formative evaluation is conducted as specified in the original application. Evaluation of specific project activities have been included in the Year I, Year II, Year III, and Year IV final reports. Evaluation data for Year V is reported below:

Table I presents the placement and program characteristics for students with severe disabilities in project participating districts (districts selected between Years I and IV). It should be noted that these data include only those students with the most severe disabilities in each district (e.g., students with severe or profound disabilities, and students with multiple disabilities). Further, these data reflect student program characteristics at the end of the 1991-1992 school year, and thus do not take into account the movement of students from the Somerset Education Center onto age-appropriate regular campuses in August, 1992. Thus, the percentage of students in age-appropriate regular school buildings for Year V is actually underestimated. Nevertheless, over the course of the project, there are highly significant changes under each variable, with a dramatic decrease in percentage of students in segregated settings (from 60.5% to 8.6%), and increases in students placed onto age-appropriate regular school campuses (29.6% to 86.5%), students receiving regularly scheduled community-based instruction (34.7% to 80.7%) and students attending at least one regular school class (14.8% to 57.4%). In addition, there have been positive, though less substantial increases in the percentage of students attending their neighborhood school.

TABLE I

All Project Participating Districts Selected During Years I - IV: Summary Student Data For Each Project Year

Year I: 1987-1988 School Year
Year II: 1988-1989 School Year
Year III: 1989-1990 School Year
Year IV: 1990-1991 School Year
Year V: 1991-1992 School Year

PROJECT YR	#STUD.	#SEG. SCH.	#INT.AGE APPROP.	#REG CLASSES	#CBI	NEIGHBORHOOD SCHOOL
YEAR I #	291	176	86	43	101	
YEAR I %		60.5	29.6	14.8	34.7	
YEAR II #	367	193	141	99	200	
YEAR II %		52.5	38.4	26.9	54.5	22.7
YEAR III #	355	153	170	120	226	
YEAR III %		43.1	47.9	33.8	63.7	23.6
YEAR IV #	296	91	185	120	209	99
YEAR IV %		30.7	62.5	40.0	70.9	33.4
YEAR V #	244	21	211	140	197	99
YEAR V %		8.6	86.5	57.4	80.7	40.6

Table II presents the cumulative figures for *only* those districts which have participated in the project all five project years. This allows direct comparisons of the original data bank with itself across each project year. Again, the changes in program characteristics are substantial over the course of the project, and parallel those of the entire data base. Segregated school placement has decreased from 61.3% to 10.7%, integrated age-appropriate placements have increased from 29.6% to 84.2%, percentage in students attending at least one regular class from 13.4% to 50.0%, and percentage of students with regularly scheduled CBI from 34.2% to 79.1%. Again, the magnitude of actual increases is underestimated, because these data do not reflect the closing of Somerset Education Center in August of this year.

TABLE II
Summary Student Data for Projects Participating All Five Years

PROJECT YR	#STUD.	#SEG. SCH.	#INT.AGE APPROP.	#REG CLASSES	#CBI
YEAR I #	284	174	84	38	97
YEAR I %		61.3	29.6	13.4	34.2
YEAR II #	284	164	105	65	162
YEAR II %		57.7	37.0	22.9	57.0
YEAR III #	265	124	110	89	160
YEAR III %		47.7	41.5	33.6	61.5
YEAR IV #	216	91	118	80	144
YEAR IV %		42.1	54.6	36.7	66.7
YEAR V #	196	21*	165*	98	155
YEAR V %		10.7*	84.2*	50.0	79.1
TOTAL % CHANGE:		-50.6*	+54.6*	+36.6	+44.9

* Note: The magnitude of change is underestimated for Year V, in that these data do not reflect the closing of Somerset Education Center, and the subsequent movement of this segregated center's students to age-appropriate regular schools in August, 1992.

Table III presents a more detailed breakdown of programming characteristics in those districts that have participated in each of the project years. Again, substantial changes in programming is reflected. Changes in programming are also reflected in the actual amounts of regular class integration and community-based instruction for students from each of the eight districts.

Table IV and Table V show data comparisons for those districts participating four years and three years respectively. Particularly strong gains occurred for the Jessamine County Schools. During the federal monitoring of Kentucky by OSEP in 1992, OSEP officials expressed to KDE staff the exemplary level of inclusion in one of the project's participating sites in that district, Warner Elementary School.

Table VI shows the enrollment of students with disabilities in separate school sites in participating school districts for each project year. As noted above, these data do not reflect the closing of Somerset Education Center in Fall, 1992.

Table III
Comparison of Year I - Year V Local District Data for Five-Year Districts

DISTRICT	#STUD.	#SEG. SCH.	#INT.AGE APPROP.	#REG CLASSES	MIN./WK	#CBI	MIN./WK
BULLITT YRI	30	0	22	9	227	3	50
BULLITT YRII	28	0	21	15	200	23	32
BULLITT YRIII	34	0	24	25	202	17	42
BULLITT YRIV	26	0	26	23	165	14	37
BULLITT YRV	16	0	16	14	300	13	60
E'TOWN YRI	6	0	6	0	0	0	0
E'TOWN YRII	8	0	8	4	220	6	90
E'TOWN YRIII	6	0	6	2	115	5	75
E'TOWN YRIV	6	0	6	2	158	6	53
E'TOWN YRV	7	0	7	1	300	7	41
CHRISTIAN YRI	20	16	4	3	45	1	120
CHRISTIAN YRII	27	21	5	4	135	2	160
CHRIST.YRIII	22	16	6	13	191	5	198
CHRISTIAN YRIV	19	12	7	9	364	5	148
CHRISTIAN YRV	20	20	19	14	317	5	148
FAYETTE YRI	68	35	31	7	50	5	40
FAYETTE YRII	68	35	42	10	60	31	98
FAYETTE YRIII	67	27	32	12	74	43	45
FAYETTE YRIV	63	26	35	13	126	58	87
FAYETTE YRV	64	64	63	18	267	59	113
JENKINS YRI	6	0	4	2	72	6	40
JENKINS YRII	6	0	4	3	100	6 1	20
JENKINS YRIII	6	0	4	4	236	6	243
JENKINS YRIV	6	0	5	5	203	4	270
JENKINS YRV	5	0	5	4	255	3	423
KENTON YRI	57	57	0	17	48	51	232
KENTON YRII	50	50	0	17	47	46	228
KENTON YRIII	47*	35	13	20	56	44	145
KENTON YRIV	23	12	10	14	342	19	113
KENTON YRV	13	0	13	13	548	7	57
SOMERSET YRI	71	66	1	0	0	14	54
SOMERSET YRII	63	58	3	4	75	20	47
SOMER.YRIII	55	46	5	3	152	18	44
SOMERSET YRIV	52	41	9	5	150	21	81
SOMERSET YRV	46	21	23	20	117	42	133
WARREN YRI	26	0	16	0	0	17	108
WARREN YRII	34	0	22	12	147	28	137
WARREN YRIII	28	0	21	10	140	22	347
WARREN YRIV	21	0	20	9	167	17	235
WARREN YRV	25	0	23	14	148	19	162

* Includes 5 Students Who Moved To Home District (Boone County) During the 1989-1990 School Year

Table IV
Comparison of Year II - Year V Local District Data for Four-Year Districts

DISTRICT	#STUD.	#SEG. SCH.	#INT.AGE APPROP.	#REG CLASSES	MIN./WK	#CBI	MIN./WK
CARROLL YRII	16	0	14	8	170	11	300
CARROLL YRIII	11	0	8	7	100	11	202
CARROLL YRIV	8	0	8	8	199	8	168
CARROLL YRV	5	0	5	5	413	5	151
COVINGTON YRII	13	0	8	10	40	3	200
COVING. YRIII	16	0	9	13	101	14	61*
COVINGTON YRIV	24	0	17	11	145	22	74
COVINGTON YRV	17	0	15	15	283	15	206

Table V
Comparison of Year III - Year V Local District Data for Three-Year Districts

DISTRICT	#STUD.	#SEG. SCH.	#INT.AGE APPROP.	#REG CLASSES	MIN./WK	#CBI	MIN./WK
JESSAM. YRIII	9	0	8	3	177	6	140
JESSAM. YRIV	12	0	12	7	243	12	218
JESSAM. YRV	12	0	12	12	409	12	226
NEWPORT YRIII	5	0	5	2	150	0	0
NEWPORT YRIV	16	0	15	12	230	5	45
NEWPORT YRV	14	0	14	10	263	9	130

Table VI
Enrollment in Separate School Sites in Participating Districts

School Year	Ft. Wright (Kenton)	Phelps (Christian)	Somerset Ed.Ctr. (Somerset)	Bluegrass (Fayette)	Forest Hills (Paducah)
Handicapping Conditions (Original)	S/PH	EMH, MH, TMH, S/PH	S/PH	S/PH, TMH Multiple	EMH, MH TMH, S/PH
1987-1988	60	40	66 (approx)	38	Not in Project
1988-1989	50	28	63	37	55
1989-1990	41	22	51	36	55
1990-1991	11	16	45	29	63
1991-1992	0	0	21	0*	Not in Project
1992-1993	0	0	0	0	Not in Project

* Exists as an integrated school with two low incidence classes; class placement depends upon the district's overall 'feeder system'.

Because it was not feasible to collect both baseline and year-end data for the projects final five districts (which entered the project in its fifth year), narrative descriptions of activities and accomplishments for each district are included in Appendix C. With the addition of these five districts to the project, a key project strategy to maintain gains and shared collegiality was the establishment of cross-district teacher work groups in the western and eastern portions of the state.

Unanticipated Benefits

Throughout the duration of the project, project resources have been enhanced through the establishment of cooperative relationships with agencies and individuals sharing mutual goals and objectives. Examples of such cooperative efforts during the past quarter include:

- Mutual planning with the Cabinet for Human Resources and the Kentucky Department of Education in the development of a State-Level Interagency Transition Agreement and accompanying manual The Kentucky Model for Interagency Individual Transition Planning for Students with Disabilities.

- A mutual planning effort with the Kentucky Deaf-Blind Intervention Project, including cooperative technical assistance to shared districts and students; the joint planning of the 1992 Faculty Seminar in May for preservice faculty in Kentucky preparing teachers of students with severe disabilities; and joint co-sponsorship for the Summer Institute.
- The participation of the Project Director as President of KY TASH
- Mutual planning and preparation with KDE and Advanced Systems, Inc. staff of the Alternate Portfolio System for educational accountability for students with moderate and severe disabilities included under Kentucky educational reform.

APPENDIX A

Advisory Board Meeting Agendas, Minutes, and Evaluations for April 29, and July 22, 1992
1992 Faculty Seminar Agenda
Final Recommendations - Higher Education Subcommittee

KENTUCKY SYSTEMS CHANGE PROJECT FOR STUDENTS WITH SEVERE DISABILITIES

ADVISORY BOARD MEETING AGENDA
WEDNESDAY, APRIL 29, 1992

9:00 Welcome

9:05 District Updates:

- Schools Are For All Kids Trainings
- Cross District Teacher Workgroups
- SPLASH Follow-Ups
- Western Ky Integrated Therapy Workshop
- Somerset/Pulaski County Status
- KY CEC Presentations with Local District Teams
- Neighborhood School Workshop/District Consultqations

Higher Education Issues Subcommittee Report:

- Results of Jan. 28th and March 4th Meetings
- Faculty Seminar Plans

Health Care Needs Manual
Project Newsletter

10:30 Break

10:45 KDE Funding for Future Systems Change: Current Status of Discussions

Discussion of Federal Systems Change Proposal

12:00 Adjourn

ADVISORY BOARD MEETING 4-29-92

Members Present: Richard Williams, Jennifer Leatherby, John Schuster, Denise Keene, Linda Dyer, Wendy Lakes, Sharon Davis, Jeanna Mullins, John Vokurka, Jayne Miller, Phyllis Bullock, Donnalie Stratton, Sammie Lambert, Bob Ryan, Bob Estreicher, Mike Burdge, Amy Reber, Jacqui Farmer, Harold Kleinert, Preston Lewis.

AGENDA:

The meeting was called to order by Harold Kleinert. Harold informed the group of project activities to date.

Schools are for All Kids Trainings: The project has conducted four California Research Institute "Schools are for All Kids" site team trainings. Evaluation results indicate that the trainings have been very well received.

Cross District Work Groups: Jacqui Farmer described the two cross district teacher work groups as up and running in Eastern and Western Kentucky. In addition, one teacher support network has begun in Jessamine County as a result of the SAFAK training.

SPLASH Follow-ups: Project staff have conducted 22 of 26 SPLASH follow-up visits, and have provided additional technical assistance during many of those visits. John Schuster inquired as to the future of SPLASH, indicating that there is a continuing need for that type of training. Preston Lewis informed the group that continuation for SPLASH had been submitted to Dr. Ted Drain's (Division for Exceptional Children's Services) office, however, competition for a small amount of money has significantly increased.

Western KY. Integrated Related Services Workshop: Jacqui Farmer reported successful evaluations for the workshop, which has been developed into an activity oriented training package. Sharon Davis responded favorably to Pam Smith's work in Jefferson County. Jefferson County will be conducting training of their own during the summer, with implementation at two new sites for '92-'93 school year.

Somerset/Pulaski County Status: Brief discussion and update on the movement of students with severe disabilities into integrated environments in Pulaski County included several related issues identified by Advisory Board Members including systematic planning with CHR to address school issues prior to placement of students at Oakwood.

KY CEC Presentations with Local District Teams: Systems Change sponsored three presentations at CEC featuring local district teams. Teams represented included: Cardinal Valley in Fayette County (Inclusive Primary Program), Warner Elementary School in Jessamine County (Inclusion for Older Elementary Age Students), Perry and Laurel County (Peer Tutoring), and Woodland Middle School (MAPS).

Neighborhood School Workshop/District Teams: Systems Change in conjuction with the Developmental Disabilities Council will be sponsoring a school team training with John McDonnell, June 10 at the French Quarter Suites in Lexington. One half-day follow-up workshops will be conducted with four local districts on the implementation of the neighborhood school concept. Those districts include: Kenton County, Covington, Jefferson County, and Jessamine County.

Facilitated Communication: Two local district staff persons and one member of the project staff attended a one-day training in Virginia on Facilitated Communication. Some success has been reported upon implementation with students. Jayne Miller suggested that any performance data available for sharing would be valuable in continuing the use of this technique.

Deaf-Blind Summer Institute: Jennifer Leatherby reported that the Deaf-Blind Project will be sponsoring a Summer Institute on "Best Practices" in the areas of vision, hearing, and communication. The Institute will be held in Lexington, July 13 - 17. The Systems Change Project will sponsor participating local district teachers.

Consultations: In addition to SPLASH follow-ups, Project Staff are providing consultations to non-project districts this spring.

Jenkins Follow-up: Jacqui Farmer reported that through inter- agency collaboration and telephone technical assistance, the situation in Jenkins has improved and has experienced significant success in providing inter-agency transition services for the student.

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Higher-Education Sub-Committee: Harold Kleinert reported progress to date on the Higher Education Sub- Committee in addressing certification and competencies related to pre-service teacher preparation. The Deaf-Blind Project's annual Faculty Seminar, to be held at the Kentucky Leadership Training Center in Faubush, May 12 -13, will focus on developing competencies/outcomes for teachers. Bill Sharpton, Professor at the University of New Orleans, will facilitate the meeting. Denise Keene suggested that attention be paid to developing competencies related to Inclusion.

Health Care Needs Manual: The Special Health Care Needs Manual is receiving final review from the KY Board of Nursing required for KDE dissemination.

Project Newsletter: The second edition of the KY Systems Change Newsletter has been completed and will be going out to Special Education Directors and teachers serving students with severe disabilities.

KDE Funding Future Systems Change: Harold Kleinert presented the status of Systems Change continuation from both KDE and federal proposal levels.

Kentucky Systems Change Project
Advisory Board Meeting Evaluation
April 29, 1992

1.0	Project Impact	
1.1	Is the Project supportive of the groups(s) or clients you represent?	5.00
1.2	Based on the information that you have, are the Project's activities impacting the programming of students with severe challenges in the district that are receiving technical assistance from staff?	4.91
1.3	How would you describe the project's impact on agencies providing services to children and youth with severe challenges (including the Kentucky Department of Education)?	4.64
2.0	Advisory Board Involvement	
2.1	Does the Advisory Board process effectively allow you to use your expertise?	4.45
2.2	Was an effective balance maintained between the time Project Staff spent presenting information and the time allowed for board members' input during this meeting?	4.45
2.3	How well has this meeting addressed the issues or priorities that you believe are pertinent to statewide systems change at this point?	4.82
2.4	This meeting was well organized.	4.82

Kentucky Systems Change Project
Subcommittee on Higher Education Issues

April 29, 1992
Agenda

12:00 Lunch Served

12:30 Review of Progress and Recommendations Thus Far

12:45 Consideration of Content to Present to the Teacher/Administrator Program Committee of the Professional Standards Board on Certification Issues K-4.

2:00 Agenda Considerations for the Faculty Seminar in May

3:00 Adjourn

MEMORANDUM

TO: Kentucky Systems Change Project Subcommittee on Higher Education Issues

FROM: Harold L. Kleinert

RE: Minutes of April 29, 1992 Meeting

DATE: May 1, 1992

Please find enclosed the minutes from our April 29th Higher Education Subcommittee Meeting in Frankfort. As you know, the next meeting will be the Kentucky Deaf-Blind Intervention Project Faculty Seminar on May 12th and May 13th at the Kentucky Leadership Center in Jabez. The major focus of that meeting will be to review present Kentucky certification competencies for teachers of students with moderate and severe disabilities, and to develop a draft set of new competencies that reflect the Kentucky Non-Diploma Program of Studies, best practices in our field, and the goals and valued outcomes of KERA. Should you require any further information on the Faculty Seminar, please contact Jennifer Leatherby of the Deaf-Blind Intervention Project (606-257-7909) or the secretary of that project, Joanne Walker at 606-257-4713.

Kentucky Systems Change Project
Higher Education Subcommittee Meeting

April 29, 1992

Members Present: Bill Berdine, Akeel Zaheer, Sheri Moore, John Vokurka, John Schuster, Linda Dyer, Harold Kleinert, Sharon Davis, Jennifer Leatherby, Preston Lewis, Jacqui Farmer, Amy Reber

Harold Kleinert opened the meeting by summarizing the major recommendations of the March 4th meeting. John Schuster asked if the recommendation for a single certificate (i.e., a Low Incidence Certificate *without* an accompanying regular education certification) was being made for the graduate or undergraduate level. Committee members indicated that the recommendation was for both levels.

After some discussion of the committee's March 4th recommendations, Harold asked Dr. Zaheer to *whom* the recommendations should be made. Dr. Zaheer replied that the committee could send their recommendations to the Teacher/Administrator Program Committee of the Education Professional Standards Board directly through *him*. He stated that we need to get all of our recommendations to him by July 15th, and that each recommendation should include a detailed analysis or rational. He suggested that CRYSTALS data, information directly from teacher trainers, needs surveys, and information from other states might all be useful in presenting our case. In addition, he stated we need to be prepared should the Professional Standards Board decide to take our recommendation for an *experimental* single certificate (Low Incidence certification *not* requiring general education certification) and decide to make it the new, standard certification program in Low Incidence.

Bill Berdine suggested that we really could not state final recommendations until we had determined the competencies for a Low Incidence certificate. Bill suggested that to expedite work on this difficult task at the Faculty Seminar, that we have an expert word processer (person!) and a Macintosh available at the seminar.

It was suggested that we ask the MidSouth Regional Resource Center to conduct a survey of several key states (e.g., Illinois, Colorado, California, Virginia, etc.) to determine the parameters of Low Incidence certification in those states, especially on the questions of dual vs. single certification, the amount of specific coursework required in Low Incidence, and the options of undergraduate and graduate level certification programs. A further recommendation was to survey *regular* education teachers and administrators to determine the competencies most critical for (a) low incidence teachers *and* (b) general education teachers in developing more inclusive programs in general education settings for students with moderate and severe disabilities. Harold will take responsibility for both of these tasks, and will try have information on the first task available at the Faculty

Seminar.

John Schuster pointed out that recommending major changes in teacher certification programs may not be effective in producing large numbers of well-trained teachers if large discrepancies exist between the requirements for emergency certification and the standard certification program. John suggested that, if we were going to make strong recommendations in certification, we should go a step further in suggesting a more equitable emergency certification process. After some discussion of this point, the committee decided to address emergency certification issues in its recommendations to the Professional Standards Board.

Kentucky Systems Change Project
Year V Advisory Board Retreat

July 22, 1992
Agenda

9:00 A.M. Continental Breakfast

9:30 Project Updates (State-Wide Issues):

- Higher Educations Subcommittee Recommendations
- Progress on Alternate Portfolio for Office of Assessment and Accountability
- Inclusive Primary School Training for 1992-1993
- Federal Proposal Status
- Health Care Needs Manual Status (Will This *Ever* End?)

In-District Project Activities Over the Final Months:

- Covington "Schools Are For All Kids"
- Neighborhood School Planning
- Inclusive Education Trainings for August - Sept.

10:45 Break

11:00 Review of Year V Data

12:00 Lunch (Served)

1:00 Formulation of Final Project Recommendations to the KDE

2:45 Evaluations, Reimbursements, and Goodbyes

3:00 Adjourn

MEMORANDUM

TO: Kentucky Systems Change Project Advisory Board Members

FROM: Harold L. Kleinert

RE: Minutes of the July 22 Advisory Board Meeting

DATE: August 4, 1992

All things in this world must end, including the current federally-funded Systems Change Project! I wish to thank each of you for the investment of your time and expertise in the guidance of our project through your participation as a member of the Advisory Board. I realize that conflicts and vacations held down attendance at the final meeting for several of our most 'dependable' and contributing members, and I especially want to thank you now.

A note of unfinished business: The Kentucky Nursing Board is currently reviewing the health care needs manual, and has suggested several minor changes. Jennifer Leatherby is currently negotiating those changes with the Nursing Board and we are hopeful of reaching 'agreement' in the very near future. I wish to thank the Board Members (Jennifer, Gene Nochta, Joan Deters, Maureen Fitzgerald, and Pat Schmidt) who attended the meeting on July 24th with the Kentucky Nursing Board and who provided critical support at this meeting for the need for this manual.

Kentucky Systems Change Project Advisory Board Meeting

Springs Inn, Lexington KY
July 22, 1992

Members Present: Jayne Miller, Jeanna Mullins, Linda Dyer, Maureen Fitzgerald, Pat Cobb, Jayne Miller, John Schuster, Wendy Lakes, Pat Schmidt, Bob Ryan, Bob Estreicher, Jennifer Leatherby, Preston Lewis, Melissa Hudson, Pam Smith, Jacqui Farmer, Harold Kleinert.

Harold Kleinert opened the meeting by informing the board that project staff have contracted with the KDE (through the IHDI) to provide inclusive primary school training to local school teams throughout the state, and that the staff have contracted with KDE and Advanced Systems to develop the alternate portfolio system and train teachers throughout the state on its use. Both contracts begin with the expiration of the federal Systems Change Project on October 1. Harold also noted that the project staff did submit a proposal for a new federal five-year project. Preston indicated that we should hear about the federal proposal in late August or early September.

Harold then reviewed the Higher Education Subcommittee's Recommendations for Low Incidence Certification Changes. He gave each board member a copy of those recommendations, along with the proposed valued outcomes (competencies) for the Low Incidence Certificate. John Schuster questioned the comparatively low reported count for emergency and probationary TMH certification requirements; Harold said he would re-check this count with Dr. Akeel Zaheer, who maintains those records for the KDE. John also noted that changes in certification requirements usually take a long time (i.e., several years) to be fully put into place. He questioned whether, in the interim, individual universities or colleges could offer the proposed new Low Incidence certification on an *experimental* basis. Harold said he would check with Dr. Zaheer on this matter as well.

Bob Estreicher noted that, as we move to neighborhood school placement for all students, special education teachers would have to learn to serve students out of their own disability category, and that certification recommendations should be made for needed competencies for teachers of students with mild disabilities as well. He suggested that we may want to look at certification for *all* students across specific age levels (e.g., K-4, 5-8, 9-12). Linda Dyer brought out that the proposed Higher Education recommendations were changes that we could make now, and that these recommendations were geared to improving both the numbers of Low Incidence teachers and their respective competencies. The board agreed that we would need to continue to look at certification changes as we move towards a merged system, and that the Higher Education Subcommittee needed to continue to function to address these more long-term challenges.

Harold then described the development of the Alternate Portfolio process for students with moderate and severe disabilities (i.e., those students for whom the regular assessment system would not be appropriate). Project staff have agreed to work with KDE and Advanced Systems, Inc. to develop the alternate portfolio and to provide state-wide training on its use. Harold described progress on the development of the alternate portfolio thus far. He noted that the KDE Alternate Portfolio Advisory Committee had met with project staff on July 6-8 to determine which of the KDE 75 valued outcomes for all students are high priority outcomes for students with moderate and severe disabilities, and how each of these outcomes could be documented for these students. This Advisory Committee identified a subset of 27 valued outcomes to be addressed in the alternate portfolio's first year. Each of the six classroom teachers on this committee are presently developing sample portfolio contents for two of their students, including a description of how each valued outcome will be documented in the portfolio. Harold, Jacqui, and Amy are presently working on portfolio scoring standards and behavioral indicators for each of the priority outcomes. Scoring standards will address student performance across multiple school, community, and home settings, and across multiple persons, including nondisabled peers. The Alternate Portfolio Advisory Committee includes Systems Change Advisory Board members Jeanna Mullins, Wendy Lakes, Jennifer Leatherby, Sharon Davis, and Sheri Moore.

Preston noted that KDE will hear about the Federal Transition Project proposal in the next two weeks. He also explained that the OVR/KDE School to Work Community-Based Transition Project will be expanded beyond the original local districts this fall.

The status of the Systems Change Project's *Services for Children with Special Health Care Needs Manual* was reviewed. Harold noted that the Kentucky Nursing Board had expressed reservations about the document and that it had set up a special committee to review the document's recommendations. Specific concerns included the role of teachers in performing health related procedures, and training guidelines. The first meeting of that committee is scheduled in Louisville for Friday, July 24. Attending that meeting will be Systems Change Board members Jennifer Leatherby (co-author of the manual), Maureen Fitzgerald, Pat Schmidt, and Gene Nochta. In addition, Joan Deters, who assisted in the development of the document, will be attending from northern Kentucky. The board also decided that it would be very valuable if Pam Smith could attend, and Harold agreed to make those arrangements.

The advisory board discussed the importance of the Health Care Needs Manual to local districts, and that the advisory board should do whatever it can to encourage and to convince the Kentucky Nursing Board to endorse the document, and (even should that fail) urge the KDE to disseminate the manual to local districts so that they have guidelines in place for these students.

The Advisory Board then reviewed Year V data for local districts. Harold noted that the data were incomplete (not all students had been entered).

Further, only quantitative data were included; more qualitative indices will be included in the final report. Board members agreed that the project should disseminate the data as evidence of the movement that has occurred in local districts over the past five years, and as an impetus to further change. It was suggested that the Final Report should be written in a 'reader-friendly' way for potential dissemination via a national journal.

After a break for lunch, the advisory board drafted the framework for several final recommendations to the KDE, by way of a project 'exit' meeting with KDE officials. These recommendations (which will be forwarded to all Advisory Board members when written in final form) included the following:

- The Higher Education Subcommittee should continue to exist to address important concerns centered around collaboration, inclusion of students, and KERA. Should the project be re-funded at the federal level, continuation of this subcommittee will be a part of its formal workscope. In any event, the Higher Education Subcommittee should be aligned with the KDE mechanism for addressing these issues, the State Special Education Advisory Board Panel.

- The *Services for Students with Special Health Care Needs Manual* is a critical guidelines and training manual for local districts, and needs to be disseminated. Information must be brought to both the Kentucky Nursing Board and to the KDE on the rational for the manual's endorsement and the limitations of the CEC statement on this issue. Letters to the KDE from physicians and from the University of Kentucky Medical School may be valuable. At any rate, the project should be prepared to disseminate the manual with its own resources to local districts should no decision be forthcoming by August 15th.

- The KDE needs to continue to focus its efforts on the implementation of LRE for all students, especially in the movement of students from segregated and self-contained placements to age-appropriate regular school campuses, to local neighborhood schools, and to membership in regular classes. Not only is this consistent with IDEA, it is also an essential element of KERA. The KDE should require districts to fully document that students cannot function in regular school environments and campuses before their removal into more segregated placements.

- The goal of a 'continuum of services' is integration into regular school and community settings. Long-term segregated placements are not justified, and the KDE needs to work closely with the Cabinet for Human Resources to support the support of students with severe disabilities in their home communities.

Finally, Preston Lewis and Harold Kleinert presented certificates of appreciation to each member of the Advisory Board, and thanked the members for their outstanding contributions over the 'long haul' of the project. Harold noted that Advisory Board members will be notified when the project hears about the status of the federal proposal, but that advisory board members will not, in any case, be "required" to serve another five years. However, they will certainly not be discouraged should they want to do so!

KENTUCKY SYSTEMS CHANGE PROJECT

FINAL ADVISORY BOARD MEETING EVALUATION

July 22, 1992

____

____

NAME REPRESENTATIVE

GROUP(S)

The **FINAL** year of the Kentucky Systems Change Project has passed quickly. You, as an Advisory Board member, can help the Project measure the impact its activities have had on persons with severe and multiple disabilities by providing your input below. A summary of the results and subsequent follow-up activities will be provided to you.

1.0 PROJECT IMPACT

1.1 Has the Project supported the group(s) or clients you represent? **4.89**

Unsupportive				Supportive
1	2	3	4	5

HOW could it have been more supportive to the group(s), clients you represent?

1.2 Based on the information that you have, evaluate the Project's impact on the programming for students with significant challenges in the districts receiving technical assistance from project staff? **4.89**

No Impact		Moderate Impact		Significant Impact
1	2	3	4	5

Describe additional activities that youwould have liked to have seen the project impact:

I think we should be very proud of input.

1.3 How would you describe the Project's impact on the Kentucky Department of Education in providing services to children and youth with significant challenges ? **4.33**

No Impact Moderate Impact Significant Impact

1 2 3 4 5

Additional Comments:

The impact on the population would not have occurred without the the vision and support of the project.

The workshops, summer institutes, etc... that have been co-sponsored by Deaf-Blind, et. - have really placed the beliefs in the position to be transulated into practice by teachers of low incidence students.

1.4 How would you describe the Project's impact on other agencies providing services to children and youth with significant challenges ? **3.44**

No Impact Moderate Impact Significant Impact

1 2 3 4 5

Additional Comments:

Medical profession needs to be integrated in Education goals for children with Special Health Care.

Probably more frustration than we deserve - this is the area of least control.

2.0 ADVISORY BOARD INVOLVEMENT

2.1 Has the Advisory Board process effectively allowed you to use your expertise? **4.33**

Ineffectively Somewhat Effectively Very
Effectively

1 2 3 4 5

2.2 Has the Advisory Board process provided you with helpful information, and opportunities in accomplishing your goals ? **4.78**

Ineffectively Somewhat Effectively Very
Effectively

1 2 3 4 5

As a teacher it is invaluable

2.3 How well has the project addressed the issues or priorities that you believe are /were pertinent to state-wide systems change until this point? **4.67**

Ineffectively Somewhat Effectively Very Effectively

1 2 3 4 5

Comments (Include priorities that you believe still need to be addressed by the advisory board):

Curtail placement of school-age individuals into institutions.
Improve services to persons with moderate and severe disabilities provided by CTCH.Comp Care.

Linkage with schools for trantions for adults.

Eliminate special education depts. and have all wide education through Early Childhood, Ele. Ed. or SEc. Ed. Dept. B).

I would like to see the Systems Change philosophy spread to the Medical and Nurshing Profession

3.0 Final Comments:

Its been a pleasure and an honor serving on the Advisory Board

Yes for the project.

I have appreciated the collaboration between Systems Change and Deaf-Blind. I think that technical assistance was provided more effectively due to this collaboration.

Excellent and professional staff. Very productive and creative.

Thanks for the opportunity to learn, grow and change as a teacher of the low incidence population.

AGENDA

FACULTY SEMINAR
KENTUCKY LEADERSHIP CONFERENCE CENTER
May 12-13, 1992

May 12, 1992

12:00 - 1:00	LUNCH
1:00 - 1:30	Welcome Review of IHE Subcommittee Dr. Harold Kleinert, KY Systems Change Jennifer Leatherby, DBIP
1:30 - 3:00	Overview of present certification and discrepancies Dr. Bill Sharpton, Facilitator New Orleans University
3:00 - 3:15	BREAK
3:15 - 4:30	Development of Competencies Based on Best Practices
6:00 - 7:00	DINNER
8:00 - 9:30	Development of Competencies -Continued (Informal) Refreshments

May 13, 1992

7:00 - 8:00	BREAKFAST
8:00 - 9:15	Development of Competencies Dr. Bill Sharpton, Facilitator
9:15 - 10:00	BREAK
10:00 - 11:45	Course Structure for Low Incidence Program Implications of KERA
11:45: - 12:00	Evaluations and Travel Vouchers Jennifer Leatherby
12:00 - 1:00	LUNCH

UK UNIVERSITY
OF KENTUCKY

Interdisciplinary Human
Development Institute

University Affiliated Program
Research and Graduate Studies
University of Kentucky
114 Mineral Industries Building
Lexington, Kentucky 40506-0051
(606) 257-1714 Fax: (606) 258-1901

July 15, 1992

Kentucky Education Profession Standards Board
Office of Teacher Education and Certification
18th Floor
Capital Plaza Tower
500 Mero St.
Frankfort, KY 40601

attn: Dr. Akeel Zaheer

Please find enclosed the recommendations for changes in TMH (Trainable Mentally Handicapped) and SPH (Severely/Profoundly Handicapped) teacher certification requirements proposed by the Higher Education Subcommittee of the Kentucky Systems Change Project for Students with Severe Disabilities Advisory Board. These recommendations are the work of a committee of five low incidence faculty members from representative Kentucky universities, local district service providers, and KDE and project staff. As an integral part of these recommendations, the Subcommittee has developed an extensive set of proposed teacher competencies (also enclosed). All Kentucky universities and colleges presently offering certification programs in TMH and SPH were invited to participate in the development of these competencies, and all but two of these personnel preparation programs were able to participate in that development.

Each recommendation includes a brief rationale and support data. Attached as appendices are the Proposed Teacher Competencies and two letters of support of the proposed changes.

Please do not hesitate to contact me at 606-257-3045 if the Standards Board is in need of further documentation or clarification. We greatly appreciate this opportunity to bring our recommendations to the Board.

Sincerely,

Harold L Kleinert

Harold L. Kleinert, Ed.D.
Project Director
Kentucky Systems Change Project for Students with Severe Disabilities

enc:

cc: Dr. Janice Weaver, Chair

Kentucky Systems Change Project Advisory Board
Higher Education Subcommittee

Recommendations for Teacher Competency and Certification Changes in Low Incidence (TMH/SPH) Disabilities

Background

The Kentucky Systems Change Project is a five-year federally funded Kentucky Department of Education (KDE) project designed to enhance the capacity of both the KDE and local school districts in providing high quality, integrated educational services for students with moderate and severe disabilities. The project's Advisory Board, which is charged with the responsibility of dealing with state-wide issues in service delivery for these students, identified pre-service issues as a critical priority. The Board subsequently established in Fall, 1991 a *Higher Education Subcommittee* to develop a set of recommendations in this area. This Higher Education Subcommittee consisted of low incidence area faculty members from the University of Kentucky, University of Louisville, Western Kentucky University and Eastern Kentucky University; local school district administrators; KDE personnel; and staff from the Kentucky Deaf-Blind Intervention Project and the Systems Change Project. As the Subcommittee proceeded with its work, faculty representatives from each state university or college offering TMH (Trainable Mentally Handicapped) and/or SPH (Severely/Profoundly Handicapped) certification were invited to join the group. The following recommendations represent a summary of the work of the Subcommittee. In addition, this report includes a proposed comprehensive set of competencies for teachers of students with low incidence disabilities. These competencies, based both on nationally recognized best practices and the requirements of KERA, provide the program foundation for the following recommendations.

Recommendations for Teacher Certification in Low Incidence Disabilities

Recommendation 1: The separate teacher certification categories of *TMH* and *SPH* should be collapsed into a single *Low Incidence* Certificate.

> *Rational:* Students with moderate (TMH) disabilities and students with severe/profound (SPH) disabilities are typically and increasingly served in the same unit or class placement by a single teacher. Thus, teachers certified in either of these areas must be prepared to work with the full range of Low Incidence disabilities. This flexibility is especially crucial in more rural districts (with low student populations), and as *all* districts begin to place students in closer proximity to their *neighborhood* schools (i.e., the school that the student would attend if he or she did not have a disability).

It has been found that students in neighborhood school programs typically have greater levels of integration in both in-school and extracurricular activities, develop more extensive social relationships and peer supports, and learn to function as a valued member of their community peer group (McDonnell, Hardman, Hightower, & Kiefer-O'Donnell, 1991). All of these outcomes are strongly supported by the educational goals and 75 valued outcomes of KERA for *all* students.

In addition, current best practices for students with moderate and severe disabilities support more flexible grouping strategies (Baumgart & Ferguson, 1991; Ford et al., 1989; Sailor et al., 1989). More flexible grouping strategies make it possible to serve students with moderate and severe disabilities more effectively in age-appropriate regular schools, as close to the student's neighborhood school as possible, and in a range of individually determined community-based settings.

Recommendation 2: Certification in Low Incidence disabilities should no longer *require* certification in regular education as well (i.e., the dual certificate), but rather prospective teachers should have the *option* of pursuing Low Incidence certification *without* regular education certification. Area requirements under the proposed Low Incidence certification should be increased from the nine semester hours of coursework presently required under TMH to no fewer than15 semester hours of coursework under the new Low Incidence Certificate.

Rational: At present, *all* teachers certified in TMH in Kentucky must also be certified in regular elementary education as well. Under this second recommendation, teachers would have the *option* of pursuing regular certification (in either the elementary, middle or secondary areas) but would not be required to do so. In addition, specific Low Incidence *area coursework* requirements would be increased to meet the demands of the proposed competencies. The full rational for this recommendation is based upon the following four considerations:

- *Proposed Low Incidence Teacher Competencies.* Faculty in Low Incidence disabilities from Kentucky's teacher preparation institutions have developed, over the past several months, a revised list of needed competencies for teachers of students with moderate and severe disabilities (Appendix A). These competencies are extensive. They are based on both nationally recognized best practices and the requirements for staff collaboration and inclusion of all students in the restructuring inherent in KERA. This set of revised competencies will require additional credit hours in the TMH area of specialization (i.e., no fewer than six semester hours), which will place even greater demands on prospective teachers in an undergraduate certification program that often already extends to five years. On the other hand, reducing this proposed list of competencies would result in teachers not being fully prepared to provide services to students with very complex and challenging needs. At present, only nine semester hours are required in the area (TMH) requirement.

- *Collaborative Skills Under KERA.* A critical element of these proposed competencies is specific course content and guided practica in supporting students with moderate and severe disabilities in *inclusive* education settings. This element supports both current best practices (Brown et al., 1991; Ford et al., 1989; Stainback & Stainback, 1992) and the intent of KERA. Present certification requirements do not reflect this critical element, nor is there sufficient time within the current TMH course requirements to address and to practice these collaborative skills.

- *A shortage of trained teachers.* The large numbers of teachers who are teaching students with moderate and severe disabilities in Kentucky under *probationary* and *emergency* certification is a good indication of the shortage of fully trained teachers in this area. According to KDE data for the 1991-1992 school year, a total of 37 teachers were approved under probationary status (i.e., regular education certification and nine semester hours of special education coursework) for the past school year and five teachers were approved under emergency status (i.e., *not* having nine hours of special education coursework and possibly not having regular certification as well). It should be further noted that the required credit hours in special education under these categories are not necessarily specific to the needs and characteristics of students with moderate and severe disabilities. Since there are 532 classroom programs for students with moderate and severe disabilities in Kentucky (1992 KDE data), nearly 8% (7.9%) of teachers in this area are currently not certified or trained for their positions.

  Eliminating the requirement for dual certification would make it possible for prospective teachers to finish the TMH certification program in four years, even with the increased competencies that have been identified above. A four year degree program (i.e., 128-134 semester hours) should result in increased recruitment of prospective teachers and a subsequent increase in the number of fully trained teachers in the field.

- *Projected training needs.* Kentucky's Annual Comprehensive System of Personnel Development (CSPD) data for 1990-1991 (the last year available) indicate that personnel needs in the area of mental retardation was the *highest* of any category of exceptionality (104 funded positions could not be filled in this category) and that both special education teachers and administrators rated training on *community-based* instructional models as one of their greatest *inservice* training needs. One emphasis of the proposed new competencies in Low Incidence Disabilities is coursework and practica in community-based instruction models and strategies. Community-based instruction is currently not addressed in Kentucky's present competency statements in TMH.

Under this proposal, there will continue to be a *required* block of regular education coursework, so designed that teachers may pursue dual certification simultaneously with Low Incidence certification, or add regular education certification at a later point without an extensive amount of additional coursework.

Recommendation 3 (Limited Option): Teachers currently certified in *regular secondary* education areas should be eligible for Low Incidence Certification without first attaining a regular *elementary* certificate. This recommendation is essential in the event that Kentucky continues to require dual (regular *and* special) certification for Low Incidence teachers (i.e., if Recommendation 2 is approved by the Professional Standards Board, then Recommendation 3 will not be necessary).

Rational: Present certification requirements in TMH state that prospective teachers must be certified in regular *elementary* education. Regular secondary certification is *not* an option, even for a teacher of high-school age students with moderate or severe disabilities. According to reports of individual faculty members in TMH teacher preparation across the state, this present 'elementary-only' requirement has resulted in the loss of a considerable number of prospective candidates in the Low Incidence area. There is no programmatic reason for this current requirement (in fact, it has served to perpetuate the false perception that *all* students with moderate and severe disabilities should be treated as primary and elementary-age students). Further, the 'elementary-only' requirement has effectively operated as a barrier to the recruitment of high quality candidates at the secondary level.

Recommendation 4: Emergency and probationary certified teachers pursuing Low Incidence certification should be required, as part of their 27 semester hours of mandated coursework, to: 1) take an instructional methods and a curriculum course specific to Low Incidence disabilities; 2) demonstrate the proposed new competencies in authentic (classroom and community) settings under the supervision of appropriate university and local school district personnel.

Rational: It is currently possible for Emergency and Probationary Certified teachers to complete the certification requirements without *specific* instructional methods and curricular courses in the Low Incidence area. Further, it is also possible to complete certification requirements without the completion of any guided practica. Since student teaching is waived for emergency and probationary certified teachers currently in the field, it is very possible to be certified without the demonstration of critical performance competencies in authentic school and community settings. This represents a very real large loophole in the current certification process.

Recommendation 5: The following competencies should be included as a part of general educators' teacher preparation programs: 1) demonstrated knowledge of the rational and goals of inclusive education programs; 2) strategies for building student and teacher supports for inclusive education; 3) cooperative learning and heterogeneous grouping strategies for inclusion; and 4) types and examples of regular classroom curricular modifications for students with mild, moderate, and severe disabilities. In addition, regular education teacher trainees should have at least one practica experience in an inclusive education classroom.

> *Rational:* Inclusive education programs, in which students with disabilities meaningfully participate as full members of regular classrooms with pull-out services only as necessary, represent best practices (Brown et al., 1991; Ford, Davern, & Schnorr, 1992; Giangreco & Putnam, 1991) as well as the intent of KERA. However, successful inclusive education programs will require not only special education teachers highly skilled in collaboration and curricular modifications, but *regular* education teachers with a working knowledge of these skills as well. Currently, prospective regular educators do take an introductory course in special education, but this is typically an overview course that does *not* provide specific information in inclusive education (especially inclusive education for students with moderate and severe disabilities) or guided experience (i.e., a practicum) in an inclusive education settings.
>
> The above competencies for regular educators were identified through a review of best practice literature in inclusive education (Baumgart & Ferguson, 1991; Lilly; 1991; Stainback & Stainback, 1989); the experience of Kentucky Systems Change Project staff in providing intensive inservices to regular educators throughout the state on inclusive education for students with moderate and severe disabilities; and a survey conducted by the project of a sample of regular education teachers in Kentucky currently providing services to students with moderate and severe disabilities in regular class and school settings.

The Higher Education Subcommittee thus respectfully requests that the Kentucky Education Professional Standards Board adopt the above recommendations for teacher certification in Low Incidence (i.e., TMH and SPH) disabilities. We believe that these proposed recommendations, if implemented, will increase the capacities of Kentucky's teachers to provide world-class programs to students with moderate and severe disabilties, and that these recommendations are consistent with both best practice in the field and the intent of KERA.

References

Baumgart, D., & Ferguson, D. L. (1991). Personal preparation: Directions for the Next Decade. In Meyer, L., Peck, C., & Brown, L. (Eds.). *Critical issues in the lives of persons with severe disabilities.* Baltimore: Paul Brookes.

Brown, L., Long, E., Udvari-Solner, A., Davis, L., VanDeventer, P., Ahlgren, C., Johnson, F., Gruenewald, L., & Jorgensen, J. (1989). The home school: Why students with severe intellectual disabilities must attend the schools of their brothers, sisters, friends, and neighbors. *Journal of the Association for Persons with Severe Handicaps, 14*(1), 1-7.

Brown, L., Shwarz, P., Udvari-Solner, A., Kampschroer, Johnson, J., Jorgensen, J., & Gruenewald (1991). How much time should students with severe intellectual disabilities spend in regular education classrooms and elsewhere? *Journal of Association for Persons with Severe Handicaps, 16*(1), 39-47.

Ford, A., Schnoor, R., Meyer, L., Davern, L., Black, J., & Dempsey, P. (1989). *The Syracuse community-referenced curriculum guide for students with moderate and severe disabilities.* Baltimore: Paul Brookes.

Ford, A., Davern, L., Schnorr, R. (1992). Inclusive education: "Making sense" of the curriculum. In Stainback, S., & Stainback, W. (Eds.), *Curriculum considerations in inclusive classrooms: Facilitating learning for all students.* Baltimore: Paul Brookes.

Giangreco, M., & Putnam, J. (1991). Supporting the education of students with severe disabilities in regular education environments. In Meyer, L., Peck, C., & Brown, L. (Eds.), *Critical issues in the lives of persons with severe disabilities.* Baltimore: Paul Brookes.

Lilly, S. (1989). Teacher preparation. In Lipsky, D. & Gartner, A. (Eds.), *Beyond separate education: Quality education for all.* Baltimore: Paul Brookes.

McDonnell, J., Hardman, M., Hightower, J., & Kiefer-O'Donnell (1991). Variables associated with in-school and after-school integration of secondary students with severe disabilities. *Education and Training in Mental Retardation, 26*(3), 243-257.

Sailor, W., Anderson, J., Halvorsen, A., Doering, K., Filler, J., & Goetz, L. (1989). *The comprehensive local school: Regular education for all students with disabilities.* Baltimore: Paul Brookes.

Stainback, S., & Stainback, W. (Eds.) (1992). *Curriculum considerations in inclusive classrooms: Facilitating learning for all students.* Baltimore: Paul Brookes.

Stainback, S., & Stainback, W. (1989). Facilitating merger through personnel preparation. In Stainback, S., Stainback, W. & Forest, M., (Eds.), *Educating all children in the mainstream of regular education*. Baltimore: Paul Brookes.

Appendix A

Proposed Low Incidence Teacher Valued Outcomes (Competencies)

VALUED OUTCOMES

The student will:

1.0 Values

1.1 Develop and articulate a philosophy for working with persons with moderate and severe disabilities.
1.2 Discuss a value-based approach of teaching children with severe disabilities focusing on ability, similarities with children without disabilities and with a focus on the family.
1.3 Identify and discuss issues of social, cultural, and intellectual diversity of severe disabilities.
1.4 Identify and discuss ethical issues related to individuals with severe disabilities (e.g., sterilization, euthanasia, educability, integration/inclusion, geriatric issues, sexuality, etc.).
1.5 Identify and discuss valued outcomes of persons with severe disabilities (e.g., community participation, independence, social membership, etc.).

2.0 Systematic Instruction

2.1 Design effective instructional programs based on both formal and informal assessments for school, home, and community settings.
2.2 Effectively apply near-errorless learning strategies, prompting procedures, and other systematic instructional procedures (e.g., time delay, system of least prompts, most to least prompting, simultaneous prompting, graduated guidance, naturalistic teaching strategies, milieu teaching strategies, and incidental teaching strategies) in school and nonschool settings using a variety of instructional grouping arrangements (e.g., individual, small group, large group; multi-age, multi-ability grouping; cooperative learning formats, etc.)..
2.3 Choose appropriate data collection strategies to evaluate student progress in instructional programs.
2.4 Make instructional decisions based on continuous program data.
2.5 Identify and use age-appropriate reinforcers for students.
2.6 Plan for and implement effective strategies for the fluency, maintenance and generalization of skills.
2.7 Use, develop and/or adapt instructional materials.
2.8 Develop and implement thematic activity-based approaches to instruction.

3.0 Assessment

3.1 State and discuss due process procedures and requirements.

3.2 Use appropriate measurement (assessment) strategies including direct observation; interviews; direct testing with norm-, criterion-, and curriculum-referenced tests; and measures that assist in developing IEP's and subsequent instructional programs with performance-based, functional and activity-based programming.

3.3 Write summaries of assessment results and activities and develop these results into appropriate educational programs and activities.

3.4 Plan and implement assessment activities for the purposes of screening, diagnosis and placement, instructional program planning, measuring student progress and program evaluation.

3.5 Involve families in assessment activities in a manner respectful of their culture.

3.6 Write appropriate and functionally based IEP's, including yearly and short-term objectives based on assessment data with various team members.

3.7 Conduct assessments of the environment, including the use of ecological inventories and curriculum catalogs to develop critical activities in four domains (i.e., domestic, community, recreational/leisure, and vocational).

3.8 Develop/adapt alternative, performance based assessments, including portfolio assessment.

3.9 Define and discuss various team models for assessment and instruction, especially collaboration.

3.10 Define and discuss various professional disciplines likely to be on assessment and instructional teams.

4.0 Technology

4.1 Operate a personal computer including word processing, spreadsheet, and desktop publishing technologies.

4.2 Support instruction with related software and facilitate learning through technology.

4.3 Apply appropriate assessment practices to the use of computers and related technologies.

4.4 Design and implement student learning activities that incorporate technology.

4.5 Use computer-based technologies to access information for class and professional development.

5.0 Communication

5.1 Assess and facilitate/enhance student use of symbolic forms of communication (e.g., words, signs and pictures, objects, symbols) using a transdisciplinary model.
5.2 Assess and enhance student use of nonsymbolic forms of communication (e.g., gestures, vocalizations, eye gaze, etc.) using a transdisciplinary model.
5.3 Complete a functional analysis of communicative intent of problem behavior and design and implement intervention strategies.
5.4 Embed/infuse basic communication skills across all activities and settings.
5.5 Provide appropriate opportunities for students to make choices across activities and settings.

6.0 Behavior Management

6.1 Be a consistent reinforcing agent.
6.2 Design and implement individual and group behavior management programs individually and with other professionals through collaborative efforts.
6.3 Monitor and analyze behavior individually and/or with other professionals to plan appropriate interventions.
6.4 Collect ongoing intervention data and modify programs based on data.
6.5 Assist others in designing and implementing behavior management programs.

7.0 Social

7.1 Develop student-centered instructional programs and strategies which result in active participation with peers and persons without disabilities, positive social outcomes, and enhanced status.
7.2 Incorporate family, multicultural, and setting-specific needs in the design, implementation, and evaluation of social skills instructional programs.
7.3 Design, implement, and evaluate instructional programs that enhance the student's social participation in valued activities in family, school, and community settings.
7.4 Facilitate participation of student, family members, and same age peers (with and without disabilities) in student centered planning.

8.0 Family

8.1 Identify family's rights and responsibilities as defined by federal and state mandates.
8.2 Effectively use formal and informal instruments to gather family input and priorities for educational programming.
8.3 Design and implement an effective system of home-school communication in collaboration with family members resulting in parent/family partnerships.
8.4 Identify critical family issues, events, and decisions from families point of view (e.g., transitional stages, grief process).
8.5 Identify agencies available in community, state and nation to assist families in meeting needs of individuals with severe disabilities.
8.6 Identify and discuss how to include families at all levels of the educational process (e.g., assessment, IEP development, programming, etc.).
8.7 Identify and discuss life planning issues (e.g., guardianship, wills, trusts, etc.).

9.0 Management

9.1 Manage student records.
9.2 Manage individual and group student daily schedules.
9.3 Manage paraprofessional daily schedules.
9.4 Manage teaching assistants.
9.5 Act as a team leader/team member.
9.6 Manage school requirements in relation to classroom procedures and operations.
9.7 Manage involvement with other school departments, organizations, and agencies.
9.8 Access and use strategies for effecting change in systems supporting persons with disabilities.
9.9 Identify key issues in site-based management.
9.10 Manage peer tutors and their schedules and coordinate efforts with their teachers.

10.0 Physical, Health, and Vitality

10.1 Demonstrate knowledge of medical terminology, implications for educational programming, and student support needs associated with various medical conditions prevalent in students with severe and multiple disabilities.
10.2 Identify and access human, agency, and published resources needed for specific students.

10.3 Use of orthotic, prosthetic, and other assistive/adaptive equipment safely and effectively.
10.4 Discuss relationship between medical interventions and physician recommendations to educational programs.
10.5 Use effective and appropriate positioning and handling procedures.
10.6 Define and discuss critical health support procedures (e.g., G-tube feeding, catheterization, ventilator assistance, suctioning, CPR).
10.7 Design and schedule educational programs that support integrated therapy.
10.8 Design, implement, and evaluate instructional programs that use student-specific adaptations and assistive technology addressing health maintenance procedures.
10.9 Demonstrate proper applications of positioning, handling, lifting, carrying and transferring for students with physical disabilities and understand implications of improper positioning, handling, etc.
10.10 Teach self-nourishment skills for students with motor impairments.
10.11 Discuss orientation and mobility training.
10.12 Embed opportunities for participation and instruction into daily self-care and health related routines for students with the most severe or multiple disabilities.
10.13 Define and discuss accessibility requirements and strategies for overcoming environmental barriers.

11.0 Systems/Legal.

11.1 Discuss major federal court cases that have impact upon special education.
11.2 Discuss and demonstrate understanding of 1973 Rehabilitation Act (Section 504) and subsequent amendments.
11.3 Discuss legal issues surrounding the education of individuals with disabilities.
11.4 Discuss and demonstrate understanding of PL 94-142 and subsequent amendments.
11.5 Discuss and demonstrate understanding and implications of the Americans With Disabilities Act.
11.6 Discuss and demonstrate understanding of service delivery system for children served under PL. 99-457.
11.7 Identify and demonstrate understanding of existing adult services (for inclusion on transition team).
11.8 Identify and access national, state and local organizations that advocate for individuals with disabilities.
11.9 Maintain confidential information in a professional manner.
11.10 Discuss and demonstrate knowledge of child/adult protective service laws.
11.11 Communicate rights to students with disabilities and their families.

12.0 Transition

12.1 Identify transition stages across the age span (Birth -- 21).
12.2 Plan and facilitate individual student transition meetings.
12.3 Plan and implement appropriate transition activities (i.e., transfer of student-specific information, equipment and/or adaptive devices).
12.4 Negotiate with parents and families issues in planning transitions.
12.5 Collaborate with sending/receiving school/ agency to implement transition planning.
12.6 Write individualized plans across age span.

13.0 Community-Based

13.1 Implement individually designed community based instructional programs.
13.2 Effectively plan for CBI (e.g., transportation, supervision, funding, insurance, and liability).
13.3 Identify and negotiate with the family and student the highest priorities for community-based instruction.
13.4 Discuss Department of Labor regulations, SSI, workmen's comp., etc., in community-based vocational training programs.
13.5 Develop community vocational training experiences that sample the range of available job opportunities.
13.6 Provide community-based job training leading to post-school employment.
13.7 Identify opportunities for student involvement in extracurricular activities (clubs, sports, friendships) and develop support for inclusion in such activities.

14.0 Professional Skills

14.1 Locate and access information and resources related to identified professional and instructional issues.
14.2 Write and/or present information in a clear, accurate and professional manner that protects student dignity and confidentiality.
14.3 Resolve programmatic barriers through negotiation with administrators, instructional personnel and family members in a positive and constructive manner.
14.4 Demonstrate knowledge of professional development opportunities at the local, state, and national levels.
14.5 Evaluate professional behavior using a professional ethics document (e.g., CEC).

14.6 Assess, train, and evaluate instructional assistants and include these individuals in planning.

15.0 Curriculum Foundations

15.1 Make curricular determinations based on age.
15.2 Use functional embedded skills approach in all environments.
15.3 Collaborate effectively with general education.
15.4 Identify stages and issues in human growth and development.

Appendix B

Letters of Support

Franklin County Schools

excellence in action

July 2, 1992

Mr. Harold Kleinert
Kentucky Systems Change Project
114 Mineral Industries Building
University of Kentucky
Lexington, KY 40506-0051

Dear Harold:

It is my understanding that the Systems Change Project has a proposal for collapsing the TMH/SPH certification to a single low incidence certificate. As you know, I have long advocated an expansion of the SPH training program. Presently, with only the University of Kentucky having such a program there is a great scarcity of teachers to meet the needs of this difficult to serve group of children. Your proposal makes a lot of sense. Even teachers with TMH certification are facing more severe disabilities than they typically would encounter in such a class. This combined certification could ensure that all teachers serving these low incidence populations have a training experience relevant to the realities we find in public schools today. Too much inservice and retraining must be done currently. School systems are not equipped to do this as efficiently as teacher training programs. To continue to do so puts children , and teachers, at risk.

The option of single certification is also a good idea. Those who wish to be dually certified can make that choice, but those who want to specifically concentrate on this population of students would be allowed to focus all of their attention to that end. With a heavy concentration on collaboration, and instruction in the appropriate utilization of paraprofessionals, such focus would contribute to the mission of the Kentucky Education Reform Act. We must have highly trained individuals to help facilitate inclusion of students with moderate to severe disabilities. Such inclusion will not occur incidentally.

916 East Main Street • P.O. Box 980 • Frankfort, Kentucky 40602 • (502) 695-6700 • FAX (502) 695-6708

Keep me posted on the status of this proposal. If I can do anything to promote the logic of such an approach please let me know. Outside of the area of emotional behavioral disabilities (BD), this is the most difficult group of children to appropriately serve.

Sincerely,

Charlie Muntz

Charlie Muntz
Director of Special Education
and Certified Personnel
Franklin County Public Schools

CM/mh

COMMONWEALTH OF KENTUCKY

DEPARTMENT OF PUBLIC ADVOCACY

1264 Louisville Road
Perimeter Park West
Frankfort, Kentucky 40601

(502) 564-8006

Protection and Advocacy Division
(502) 564-2967

June 30, 1992

Dr. Harold L. Kleinert, Director
Kentucky Systems Change Project
Human Development Institute
114 Mineral Industries Building
University of Kentucky
Lexington, Kentucky 40506-0051

Dear Dr. Kleinert:

We have reviewed the recommendations for teachers of students with moderate and severe disabilities developed by your project's Higher Education Subcommittee. We would like to lend our strong support to the recommendations for a single low incidence certification (no longer requiring regular education certification); for the additional requirements for emergency certification, especially the practica requirement; and for the enhancement of general teacher preparation programs.

As the agency in Kentucky charged with advocating the rights of citizens with disabilities, we have represented hundreds of students with moderate and severe disabilities throughout the Commonwealth. One of the primary barriers to quality, integrated educational services to these students is the lack of knowledge and expertise among the state's teachers. The vast majority of teachers responsible for providing educational services to students with moderate and severe disabilities possess TMH or emergency certification. We have found that neither of these certifications ensures that teachers are adequately prepared to meet the educational needs of our clients.

The teachers we encounter do not have the knowledge base or the technical skills to serve students with severe disabilities. They are completely unprepared to develop strategies for integrating these students into typical educational settings. As KERA becomes fully implemented, parents, advocates, and compliance monitors will be holding school systems accountable for the educational progress of students with moderate and severe disabilities. The expectation of KERA is that these students will be learning and participating alongside their peers who do not happen to have disabilities. General education practitioners will need the support and expertise of teachers of students with moderate and severe disabilities as they begin to address these students' needs in the general education setting.

An Equal Opportunity Employer M/F/H

The competencies which TMH and emergency certified teachers currently demonstrate will not enable them to design curricular modifications, facilitate partial participation, function as collaborators--all competencies which will be necessary to make KERA a reality for students with moderate and severe disabilities.

Sincerely,

Maureen Fitzgerald, Supervisor
Educational Advocacy Section
Protection and Advocacy Division

MF/lp

APPENDIX B

Agendas and Evaluation Summaries for:

Somerset SPLASH training,
Covington Schools Are For All Kids Level II Site Team Training,
John McDonnell Neighborhood School Training and Follow-Ups,
Western Kentucky Integrated Therapy Workshop Training,
Jefferson County Alternate Portfolio Trainings, and
Summer Institute (co-sponsored with Kentucky Deaf-Blind Intervention Project)

SOMERSET PULASKI COUNTY SCHOOLS
SPLASH TRAINING
SPRING, 1992

DAY III: TUESDAY, APRIL 14TH

8:00 - 9:45	Facilitating Communication in the Context of Activity-Based Instruction	Donna Sutherland
9:45 - 10:00	Break	
10:00 - 11:15	Facilitating Communication - cont.	Donna Sutherland
12:15 - 1:45	Vocational Preparation Strategies for Students with Severe Disabilities and Challenging Behaviors	Milton Tyree
1:45 - 2:00	Break	
2:00 - 3:00	Vocational Preparation Strategies - cont.	Milton Tyree

DAY IV: WEDNESDAY, APRIL 15

8:00 - 9:45	Support Networks and Circles of Friends: Making Integration Work	Harold Kleinert
9:45 - 10:00	Break	
10:00 - 11:30	Woodland (Kenton Co.) Middle School Panel: Integration for Students with Severe Disabilities and Challenging Behaviors	
11:30 - 12:00	Educational Goals in Regular Classes and Adaptations for Participation	Harold Kleinert
12:00 - 1:00	Lunch	
1:00 - 1:20	Roles in Integration	Harold Kleinert
1:20 - 2:10	Systems Change Strategies	Harold Kleinert
2:10 - 2:20	Break	
2:20 - 2:40	Attitude Activity	Harold Kleinert
2:40 - 3:00	Complete Team Action Plans	Harold Kleinert

SPLASH Training
Module II
Somerset, Ky
April 14, 1992

1. Organization

a. Were the sessions well organized?	4.40
b. Was discussion encouraged?	3.93
c. Were topics relevant to your job?	4.20
d. Was adequate time allowed for each session?	3.71

2. Presentation

a. Were the trainers well prepared?	4.47
b. Did the presentations stimulate your interest?	4.13
c. Were questions adequately answered?	4.27
d. Were the presentations clear and concise?	4.50
e. Were the meeting facilities adequate?	4.33

3. Overall Rating

a. Did the sessions meet your professional needs?	4.00
b. Would you recommend these training sessions to other professionals?	3.80

4. Which presentations/activities were most valuable for you? Why?

Both
Work presentation - preparing our client for work
Communication & vocational aspects - both good
Discussion of augmentative training

5. Which parts, if any, would you change? Why?

6. General Comments:

Need a full day with Milton Tyree
Very good, interesting
Enjoyable

SPLASH Training
Module II
Somerset, Ky
April 15, 1992

1. Organization

a.	Were the sessions well organized?	4.46
b.	Was discussion encouraged?	4.62
c.	Were topics relevant to your job?	4.27
d.	Was adequate time allowed for each session?	4.15

2. Presentation

a.	Were the trainers well prepared?	4.65
b.	Did the presentations stimulate your interest?	4.15
c.	Were question adequately answered?	4.19
d.	Were the presentations clear & concise?	4.42
e.	Were the meeting facilities adequate?	4.54

3. Overall Rating

a.	Did the sessions meet your professional needs?	4.23
b.	Would you recommend these training sessions to other professionals?	4.42

4. Which presentations/activities were most valuable for you? Why?

Simulations
Panel discussion - they've been there
Question & answer
The circle of friends activity, it brought home the lack of "real" relationships that SPH students have.
Small group activities - more input & discussion
Discussion, video, group activities
The team from Woodland Middle School was very informative. They show it can work.
The Woodland School staff
Circle of friends topic. Awareness of obstacles to training.
The entire program
Film
It all sounded good but how do you do this? No instruction on how to go about integrating students or CBI.
All of it
Panel from the Kenton Co School System
Circle of friends

5. Which parts, if any, would you change? Why?

None
None
Should have involved those teachers who will do the integrating
I would conduct this training within a school setting before working with these kids.
I feel one day should have been at a school who has intgration at work.

On hands, practical training vs. armchair sessions
None
None
None
Involve the people who are going to implement the integration in the classroom

6. General Comments:

Apply this info directly to the kids involved
Please provide additional SPLASH training for regular education staff
Interesting & topical
Very interesting
Over all, good - very informative
Too much training goes to the wrong people

SCHOOLS ARE FOR ALL KIDS

SITE TEAM LEVEL II TRAINING

Covington, KY

Tuesday, June 9 1992

9:00	Introduction/ Objectives Effective Primary Classrooms Integration / Inclusion Mini-lecture Supports to Inclusion Jigsaw
10:30	Break
10:40	Circles of Friends Team Action Plan Roles in the Integration Process
12:00	Lunch
12:45	Making Meetings Work The Change Process in Schools
2:00	Break
2:10	The Change Process in Schools Story Boards
3:00	Evaluations

SCHOOLS ARE FOR ALL KIDS

SITE TEAM LEVEL II

Covington, KY

Wednesday, June 10

9:00	Interview Activity Attitude Activity Adaptations Mini-Lecture Grouping Strategies
10:30	Break
10:40	Grouping Strategies Debate Cooperative Learning Individual Student Planning
12:00	Lunch
12:45	Individualized Student Planning
2:00	Break
2:10	Group Vision/Final Action Plan Inclusion Myths or Truths One Sheet of Paper Activity
3:00	Expense Vouchers and Evaluations

SCHOOLS ARE FOR ALL KIDS
COVINGTON, KY
JUNE 9, 1992

1. ORGANIZATION

a.	Were the sessions well organized?	4.89
b.	Was discussion encouraged?	4.95
c.	Were topics relevant to your job?	4.79
d.	Was adequate time allowed for each session?	4.53

2. Presentation

a.	Were the trainers well prepared?	4.84
b.	Did the presentations stimulate your interest?	4.63
c.	Were questions adequately answered?	4.68
d.	Were the presentations clear and concise?	4.74
e.	Were the meeting facilities adequate?	4.68

3. Overall Rating:

a.	Did the sessions meet your professional needs?	4.58
b.	Would you recommend these training sessions to other people?	4.79

4. Which presentations/activities were most valuable for you? Why?

Strategies, gave me ideas to implement
Circle of friends - a good way to include a new student
Mapping, circle of friends
Roles in the integration process
"Peer Power", Mapping, Agenda Planning - all can be used at my school
Hopefully this workshop will open new doors for people
Circle of friends - explains the importance that everyone makes
Circle of friends - can do in classroom next year
Change, friends
Support
Circle of friends, Mapping
Mapping
Maps - things to do to get ready for student
The ones where we did group activities
Mapping, Circle of Friends

5. Which parts, if any, would you change?

More suitable for inner city school implementation
No
None
Could you number the intro pages?
None
I normally have something for this but not today

6. General Comments:

Need to think more about inner city problems
Well organized
I've learned a great deal on what I need to do to improve my position and attitude
Well organized
I enjoyed the session - it went quickly
Things moved very quickly. I like that.

SCHOOLS ARE FOR ALL KIDS
COVINGTON, KY
JUNE 10, 1992

1. ORGANIZATION

a	Were the sessions well organized?	4.80
b.	Was discussion encouraged?	4.90
c	Were topics relevant to your job?	4.45
d	Was adequate time allowed for each session?	4.50

2. Presentation

a	Were the trainers well prepared?	4.85
b.	Did the presentations stimulate your interest?	4.60
c	Were questions adequately answered?	4.50
d	Were the presentations clear and concise?	4.65
e	Were the meeting facilities adequate?	4.80

3. Overall Rating:

a	Did the sessions meet your professional needs?	4.35
b.	Would you recommend these training sessions to other people?	4.60

4. Which presentations/activities were most valuable for you? Why?

Knowing we are not alone
Activities
Discussions with peers - how everyone is coping with new rules & regulations
Knowing we weren't alone
Goals for school
Circle of Friends
Planning - gave more insight into long-short term goals which must be planned out carefully
How to include handicapped into classrooms
Matrix
IEP Classroom activity analysis & activity matrix will help us to prepare for special needs children
Enjoyed the group process

5. Which parts, if any, would you change?

Too difficult to fill out IEP's, etc on students you do not know
Would like workshop to center more on problems that could arise
Different time of the year instead of the end
More parental involvemnt
Don't change anything

6. General Comments:

Notebook with samples and empty pages to use was great to get
Great classes, the remainder of the faculty could benefit
Overall - good!!
I've enjoyed the meetings and have learned what that will hops in my position.
I found the session informative & useful. I appreciate the fact that the aides were here because they are so important to our success.
Well prepared and organized

BEST COPY AVAILABLE

Interdisciplinary Human Development Institute
University of Kentucky

Neighborhood School Conference
Dr. John McDonnell, Presenter

French Quarter Suites
Lexington, KY

June 10, 1992

(Developed in Collaboration with the Kentucky Systems Change Project)

Agenda:

9:00 A.M.	Coffee/Registration
9:30	Introduction and Rational for Neighborhood Schools for All Students
10:00	Relationship of Neighborhood Schools to Educational Reform and Specifically to KERA
10:15	Strategies and Service Delivery Models for Neighborhood Schools
10:45	Break
11:00	Strategies and Service Delivery Models - Cont.
12:00	Lunch (provided)
1:00	District Level Planning Process for Neighborhood Schools
2:00	Break
2:15	District Planning Process - Cont.
3:00	Reimbursement Forms and Evaluations

NEIGHBORHOOD SCHOOLS WORKSHOP
DR. JOHN MCDONNELL
JUNE 10, 1992

1. ORGANIZATION

a. Were the sessions well organized?	4.67
b. Was discussion encouraged?	4.58
c. Were topics relevant to your job?	4.58
d. Was adequate time allowed for each session?	4.58

2. Presentation

a. Were the trainers well prepared?	4.94
b. Did the presentations stimulate your interest?	4.91
c. Were questions adequately answered?	4.67
d. Were the presentations clear and concise?	4.82
e. Were the meeting facilities adequate?	4.91

3. Overall Rating:

a. Did the sessions meet your professional needs?	4.64
b. Would you recommend these training sessions to other people?	4.76

4. Which presentations/activities were most valuable for you? Why?

Individual school discussion & decisions
Yes - loved that the practical issues were addressed
Strategies to support integration in elem. school - for planning purposes
Small group discussions & sharing between groups!
I very much liked the size of this group!
Groups discussion by district
Afternoon - more interaction was encouraged
PM Sessions
Introductory material/presentation, district level focus
The group meetings, to discuss with other districts
District planning
Information on inclusion to better implement the program
Summary of research base
Relationship to school reform
District planning/summary
Whole day
All of it was educational
Phases of implementation plus possible barriers
All
Discussions - need more - not enough Q & A opportunities - alter approach of one-way info acquisition

5. Which parts, if any, would you change?

More interactions in the morning
AM - handouts for topics & group discussion of handouts
None
2 days instead of 1
None
None
Have this guy print his overheads for distribution to all we need info not notetaking practice.

6. General Comments:

Thanks
Excellent!
Very enjoyable!
Very Good!
Please identify the participants in the future to gain insight into their perspectives.
Excellent -timely
Excellent presenter because he is doing the implementation
Very good
It was refreshing to learn through this presentation that the district, precisely the elem. school in which I work, is already implementing & very committed to inclusion. Dr. McDonnell is obviously committed to his task & this is refreshing. An excellent presentation.
Very good workshop!
Excellent
Needs to be presented to administrators, school boards, school councils
Good in-service
Excellent! Thank you!
Interesting - supportive of ideas & goals of county
Interesting - good speaker
Great! Thank you
I would love to see more administrators & regular teachers involved form our district.
The info is extremely important 7 I use most of this stuff now. Printed notes - let us focus on content not process of info acquisition on the blank page. Mass quantity note taking hinders the info acquisition stages. Good program.

Neighborhood Schools for All Students Training
Dr. John McDonnell

Agenda for Follow-Up Meetings in Individual Districts for Neighborhood School Planning

June 9th and June 10th, 1992

1.0 Introductions and Brief Review of June 10th Workshop - (Dr. John McDonnell). Questions on Workshop Content.

2.0 Description of Current Unit Placements for District's Students with Moderate and Severe Disabilities (i.e., How are units and/ or students with moderate/severe disabilities currently placed within the district's schools? Are there any *current* district plans to change that pattern of placement?). This should be presented by the District Director of Special Education.

3.0 Identification and Discussion of Current District Barriers to Neighborhood School Placement (Full Group).

4.0 Formulation of Plan of Action or "Next Steps" in District Planning Process (Full Group).

Summary of Dr. John McDonnell Meetings with Individual Districts on Neighborhood School Planning

June 11 and June 12, 1992

June 11th (AM): Kenton County

In attendance: Dr. McDonnell, Harold Kleinert and Amy Reber of the Systems Change Project, Dr. Dan O'Brien and Mr. Bob Estreicher, Director and Associate Director for Special Education in Kenton County, John Keiger, Principal of River Ridge Elementary and Mr. Compton, Principal of White Tower Elementary, district preschool coordinator Stephanie Sciamanna and integration facilitator/district consultant Mike Burdge.

Plans for the coming school year were discussed in reference to district movement towards neighborhood schools. White Tower will serve students with moderate and severe disabilities from the southern part of the county (a cachement area of three schools), and Mike Burdge will be assigned fulltime to that school to promote inclusive placements for all of these students.

Taylor Mill will continue to serve the students in its cachement area, including two students fully included in the primary program. River Ridge, the district's new elementary school complex, will support three low incidence units (one from Parkhills and two from Redwood, a segregated school program that is closing this year).

At the middle school level, a Low Incidence unit will be established at Turkey Foot Middle for those students in the Turkey Foot cachement area. Woodlawn will continue to serve students from its own cachement area, as well as students from the Twenhofle Middle area for next year. (All district students at the high school level are currently in their neighborhood schools).

Dr. McDonnell suggested that the district's plan to support all students coming from preschool into ungraded primary programs within their respective neighborhood schools is an excellent strategy for converting to neighborhood schools over a 5-6 year period. Also discussed were the future of the clustered programs at the elementary level at White Tower and especially River Ridge. Dr. McDonnell suggested that a good intermediate strategy would be to move students from clustered programs to neighborhood schools in coordination with the identification and support of preschool students with moderate and severe disabilities who would be attending those schools.

Staffing strategies discussed for neighborhood schools in Kenton County included both the shared caseload (a full-time Low Incidence teacher within a school) and the itinerant model (a Low Incidence teacher with

INTEGRATING RELATED SERVICES WORKSHOP

SCHEDULE

8:00 - 8:30	COFFEE / DONUTS
8:30 - 9:30	TRANS-DISCIPLINARY TEAMING ACTIVITY
9:30 - 10:15	SUPPORT IS - SUPPORT IS NOT ACTIVITY
10:15 - 10:30	BREAK
10:30 - 12:00	INTEGRATING RELATED SERVICE JIGSAW - BLOCK SCHEDULES - EMBEDDING RELATED SERVICE OBJECTIVES - INTEGRATED SERVICE DELIVERY - CONSULTATION, TRAINING, ROLE RELEASE - INFORMATION EXCHANGE TEAM MEETINGS - IMPLEMENTING TRANS-DISCIPLINARY SERVICE
12:00 - 1:00	LUNCH
1:00 - 2:15	DEVELOPING TRANS-DISCIPLINARY EMBEDDED SKILL IEPS
2:15 - 2:30	BREAK
2:30 - 2:45	DISCIPLINE MYTHS AND TRUTHS LESSONS FROM THE GEESE
2:45 - 3:30	DISTRICT IMPLEMENTATION ACTION PLAN

INTEGRATING RELATED SERVICES WKSHP
HOPKINSVILLE, KY
4/23/92

1. Organization

a. Were the sessions well organized?	4.86
b. Was discussion encouraged?	4.87
c. Were topics relevant to your job?	4.73
d. Was adequate time allowed for each session?	4.67

2. Presentation

a. Was the trainer well prepared?	4.93
b. Did the presentations stimulate your interest?	4.60
c. Were questions adequately answered?	4.47
d. Were the presentations clear and concise?	4.73
e. Were the meeting facilities adequate?	4.93

3. Overall Rating

a. Did the sessions meet your professional needs?	4.47
b. Would you recommend these training sessions to other professionals?	4.67

4. Which presentations/activities were most valuable for you? Why?

**Matrix - hard but it would be good for data keeping
Hands on
Being able to have discussion with all disciplines. This makes transdisciplinary teaming look wonderful.
All of it --> makes SHIPP training more real and daily interaction between professionals
All
Embedded skills IEP
Hands on - multidisciplinary, etc.
Learning to pick out the embedded skills

5. Which parts, if any, would you change? Why?

More time to talk about where to go from here
None
Blank & completed worksheets as guides for further use.
Administrator would be here to learn.

6. General Comments:

Come play with us!
Good use of addressing different learning types
Very good course!
Thanks!
This is the first time that we've had the opportunity to get together as a team.
Great job! I appreciate the handouts, "hands-on" activities in afternoon.

Jefferson County District Alternate Assessment Leaders Training
Wednesday, Sept. 16th, 1992

Interdisciplinary Human Development Institute
University of Kentucky

9:00 A.M.	Welcome, Introductions, and Overview
9:15	Alternate Portfolio Jigsaw: Putting All the Pieces Together
10:15	Break
10:30	Individual Students: Schedules, Portfolio Evidence, and Valued Outcomes
12:00	Lunch
1:00	Planning Portfolios: Turning Activities Into Products and Productions
2:00	District Level Training: Training Issues and Logistics - Planning for Sept. 25th
2:45	Critique of Training
3:00	Adjourn

Kentucky Systems Change Project

Jefferson County Public Schools
Alternate Portfolio Training

Friday, Sept. 25, 1992
Agenda

8:30 Registration/Coffee

9:00 Overview of Training

9:10 Key Components of the Alternate Portfolio: Jigsaw Activity

10:30 Break

10:40 Questions and Answers

11:00 Mini Lecture on Student Schedules and Identifying Portfolio Contents

11:10 Identifying Portfolio Entries for Sample Students: Small Group Activity

11:45 Report to Large Group

12:00 Lunch (served on site)

12:45 Answering Key Concerns (Small Group Activity)

1:00 Identifying Portfolio Items for One of Your Own Students (Small Group)

1:35 Report Back to Large Group

1:50 Logistical Concerns: Need For Further Training and Support in the Alternate Portfolio Process

2:15 Training Evaluation

2:20 Break

2:30 Next JCPS Training Session

ISSUES REGARDING STUDENTS WITH DUAL SENSORY IMPAIRMENTS

SUMMER INSTITUTE
JULY 13 - 17, 1991

University of Kentucky, Department of Special Education
Deaf-Blind Intervention Program
Interdisciplinary Human Development Institute Systems Change Project
Kentucky Department of Education

JULY 13 8:30 a.m. - 4:30 p.m.	**TOPIC:** Presenter:	**ASSESSMENT** Robbie Blaha, Texas Deaf Blind Institute
JULY 14 8:30 a.m. - 4:30 p.m.	**TOPIC:** Presenters:	**VISION** Dr. Sheri Moore, University of Louisville Diane Haynes, Deaf-Blind Intervention Program
JULY 15 8:30 a.m. - 4:30 p.m.	**TOPIC:** Presenter:	**HEARING** Jim Durkel, Texas Deaf Blind Institute
JULY 16 8:30 a.m. - 4:30 p.m.	**TOPIC:** Presenter:	**COMMUNICATION** Jim Durkel, Texas Deaf Blind Institute
JULY 17 8:30 a.m. - Lunch	**TOPIC:** Presenters:	**INTEGRATING RELATED SERVICES** Madisonville North Hopkins High School Professional Panel
JULY 17 Afternoon Session	**TOPIC:** Presenters:	**FAMILY ISSUES** Parent Panel

AGENDA

SUMMER INSTITUTE
JULY 14, 1992

TOPIC: VISION

8:30	- 10:00	Introduction Small Group Activities Discussion
10:10	- 10:30	BREAK
10:30	- 12:30	Low Vision Principles
12:30	- 1:30	LUNCH
1:30	- 3:30	Small Group Activity Unique Characteristics and Learning Styles of Children Who are Visually Impaired
3:30	- 3.45	BREAK
3:45	- 4:30	Wrap-up

1992 Summer Institute Evaluation Scale

Date: July 13, 1992

Topic: Issues Regarding Students with D.S.I. Assessment - Robbie Blaha

# = 42 (not all participants completed evaluations)

On a scale from 7 (high) to 1 (low) the participants rated the session as:

		Range	Average
1.	The **organization** of today's content was	5-7	6.2
2.	The **objectives** to today's content were:	5-7	6.7
3.	The **work of the presenter**(s) today was:	6-7	6.8
4.	The **activities** for today's content were:	6-7	6.8
5.	The **scope** (coverage) of today's content was:	5-7	6.3
6.	My **attendance** today should prove:	5-7	6.4
7.	**Overall**, I consider this training:	6-7	6.9
8.	Need **additional information** about this topic?	Yes = 32	No = 6

MORE INFORMATION ABOUT?

- more information on working with younger children and recognizing their needs.
- more information on R.O.P.
- Gentle teaching
- I would like more information on programming including examples and some specifics
- I would like information on communication techniques used with this population.
- Autism.
- Application to the hearing impaired - strategies, etc
- CRIB
- I would like some of the overheads.
- more about ROP.
- More Robbie (next yr?) may have more information when I go thru handouts.
- I would like to have copy of the "state handout".
- ROP, Aniridia, Glaucoma
- teaching strategies.
- COMMUNICATION - BEHAVIORAL FUNCTIONS
- Programming issues regarding students with dual sensory impairments.
- Just follow ups as information changes.
- I feel you can not know enough on these individuals and each one has unique problems.
- Assessment.
- Classroom modifications and services for visually handicapped.
- ROP - Infants/Toddlers Activities for parents to maximize vision.
- How to get this across State to classroom teachers.
- assessing severe/profoundly handicapped individuals - present criteria is unrealistic.

- More, more, more treatment techniques.
- continued in-depth information.
- more information on adapting instruction to deal with these impairments.

THE STRONGER FEATURES TODAY WERE:

- The speaker was interesting, knew her subject and it was obvious she enjoys working with children.
- The presenter was very interesting and upbeat in nature and presented much helpful information that I can apply in working with the children I teach.
- Presenter's enthusiasm and knowledge
- Presenter was interesting - excellent information and handouts
- She used laymans terms and was very graphic in her explanations. She used excellent examples and analogies to bring it all home to the participant
- it addressed issues of visual assessment/responses that I may have been overlooking in behavioral observations.
- Ms. Blaha was very knowledgeable and use practical, functional technique with the children she worked with.
- Robbie kept everyone in an active alert or quiet alert state!! Presented real kids with real problems - not just theory!
- The presenter was qualified, competent.
- it was very clear, very informative. Gave me a new perspective about DB, well laid out.
- I have three students that have visual impairments and I know very little about working with them.
- the presenter was very interesting and knowledgeable.
- presenter knows the "nuts and bolts".
- theoretical ideas illustrated with practical examples.
- the presenter - Robbie - was wonderfully entertaining.
- very informative.
- it was very practical!
- the information and application were very practical.
- it was presented clearly and with a much needed humor when the subject matter got precise. I didn't know eye charts could be fun!
- Robbie was very knowledgeable and obviously is experienced.
- I did not know very much about the subject and it was presented in such a way that even I could follow and understand.
- information was clearly, honestly presented. Concepts such as: people are teachable when happiest; the extreme need for communication; the information derived from "self-stim" is crucial; the significance of routine, etc - were very valuable.
- this topic (assessment of students with dual sensory impairments) is not often addressed at conferences.
- practical information directly related to classroom routines.
- Robbie was a wonderful presenter. She presented very basic, very practical information.
- I learned ways to identify visual problems through observations.
- the speaker was fabulous.
- Presenter was knowledgeable, innovative and interesting delivery.
- Speaker was interesting, knowledgeable. Good description of children, behaviors and practical activities.
- very practical - easily understood, humorous.
- consultant was interesting, informative and realistic.
- it dealt with practical ideas.
- Robbie has given information on a level that everyone can understand.

- Robbie could relate to our needs, feelings and experiences.
- use-able ideas for classroom.
- It's very hard to find information on assessing kids with dual sensory impairments.

I WISH THAT:

- There had been more time to see tapes of case studies.
- We could continue with additional summer institutes as I feel they are invaluable and provide a lot of support to working professionals.
- others I work/consult with had attended
- I could attend the 5 day seminar
- I was able to attend all 5 day.
- there were more professionals in the medical field with more flexibility.
- she had more time to present.
- there were more speakers like this very competent - yet presenting information clearly.
- she (presenter) could travel all over the state of KY to present her information.
- there had been an evening component so we could cover ROD.
- I could get much more in-service on this subject.
- I could hear more from Ms. Blaha - more programming ideas.
- We need a week -
- KSD and KSB had participated.
- I had more time with Robbie Blaha and had this workshop about 5 years ago.
- there had been more time for this topic.
- I could attend all week for all the information I have received.
- she had been a bit more organized and more examples with the videos had been shown.
- Ms. Blaha could have had more time. Clearly there was a lot of information that she had to rush through. But I understand the time constraints that she was under.
- there was more time. I wish that more "professionals" could hear this message.
- there had been more time. I think any problems with coverage, organization, etc were due to time constraints.
- there had been more time to ROP in depth.
- Robbie Blaha could extend on each of the visual disabilities and the programs she had.
- we had more in-depth information regarding assessment.
- We had Robbie Blaha at our school for blind!
- we had had an agenda and map to Springs Inn, presentation more varied, lights were on after lunch (had to watch video after lunch in dim light).
- Robbie could be in every school district in KY.
- Robbie had more than 1 day.
- I had taped the session.

GENERAL COMMENTS:

- very informative
- This has been one of the best workshops that I have attended.
- This is one of the best seminars that I have attended. Please bring Robbie back!
- Speaker Robbie Blaha was excellent in her knowledge and presentation.
- Great presentation.
- Excellent speaker - will look for her at other conferences.
- Thanks so much. It has been very informative. It was a well organized program.
- Terrific! She kept everyone's interest.
- I have learned more about visual impairments today than I have learned in the last 4 years.
- Interesting speaker, good rapport with audience.

- Ms. Blahas' style was interesting and exceptional. As an audiologist, she provided me with some useful items to be used.
- Thanks again for excellent, useful information!
- Very good presenter!
- Great overview of the subject.
- I really enjoyed listening to Robbie and felt everything she had to say was informative.
- I did feel a bit discouraged as the day progressed as it seemed that the work is so hard and even very experienced people have great difficulty "figuring out" strategies and effective plans.
- Ms Blaha was an entertaining very informative speaker that I would like to see invited back to this state. As a matter of fact I wish she could be a consultant in this state.
- Great workshop!
- Ms Blaha was an excellent presenter. The handouts look as if they will be helpful in the future.
- Very informational and immediately useful. Thanks!
- Lighting was not very good!
- Great information !!!! You think you can not sit in conference from 8 - 5 but this only seemed a couple of hours!!!
- Excellent!
- Good presentation on assessment - practical and functional.
- Wonderful presenter!!! Could listen to her all day.
- Excellent today.
- Very good information.
- Extremely interesting.
- Thanks.

1992 Summer Institute Evaluation Scale

Date: July 14, 1992

Topic: Vision
Sheri Moore & Diane Haynes

= 14

On a scale from 7 (high) to 1 (low) the participants rated the session as:

		Range	Average
1.	The **organization** of today's content was	6-7	6.9
2.	The **objectives** to today's content were:	6-7	6.8
3.	The **work of the presenter**(s) today was:	6-7	6.9
4.	The **activities** for today's content were:	6-7	6.9
5.	The **scope** (coverage) of today's content was:	6-7	6.7
6.	My **attendance** today should prove:	6-7	6.9
7.	**Overall,** I consider this training:	6-7	6.9
8.	Need **additional information** about this topic?	Yes = 7	No = 2

MORE INFORMATION ABOUT?

- I would like information on students with no vision at all.
- materials.
- More workshops on functional visual assessment in the home.
- O & M
- Group activities for a class of the visually impaired.
- Additional programming information.

THE STRONGER FEATURES TODAY WERE:

- I was involved actively - i.e. simulations
- it dealt with the practical aspects.
- The activities really made you think about how it feels to have a visual impairment.
- practical, good presentation. Kept moving.
- activities, information given together - more impact and makes it great for a learner who is less than an auditory learner.
- hands on, application, realistic.
- we were given the opportunity to be involved in hands on activities. This always proves to be most beneficial to me.
- I can take what I learned and directly use it in my class.
- its practical. I can apply everything I have learned.
- Dr. Moore looks so lovely in her new dress, a gentle, classy yet powerful look!
- It was not boring - a good variety of participation.

- participants became very involved with activities. It was truly active learning.
- we had personal experiences and used hand-on activities which taught the principles in a lasting revealing way.
- It put concepts on a practical level and in a way that hits home.

I WISH THAT:

- Everyone could at sometime experience what it is like to have a visual impairment.
- more time.
- we could have more workshops like this one.
- more school administrators would attend wonderful seminars and workshops like this maybe they would be more sensitive.
- everything I've learned makes a difference in treatment.
- I could do this more often.

GENERAL COMMENTS:

- Great - Thanks!
- Great job.
- wonderful Day.
- This workshop should be mandatory for ALL special education teachers.
- Very interesting and informative.
- I feel this session increased my understanding of the feelings of a blind or VI child (as much as possible for a sighted person, that is).
- Great day! Loved the real concepts.
- Activities were good and very non-threatening. Like the matrix and videos. The presenters were wonderful.

1992 Summer Institute Evaluation Scale

Date: July 15 1992

Topic: Hearing
Jim Durkel

= 14

On a scale from 7 (high) to 1 (low) the participants rated the session as:

		Range	Average
1.	The **organization** of today's content was	6-7	6.6
2.	The **objectives** to today's content were:	5-7	6.6
3.	The **work of** the **presenter**(s) today was:	6-7	6.8
4.	The **activities** for today's content were:	6-7	6.6
5.	The **scope** (coverage) of today's content was:	5-7	6.4
6.	My **attendance** today should prove:	5-7	6.6
7.	**Overall**, I consider this training:	5-7	6.6
8.	Need **additional information** about this topic?	Yes = 7	No = 1

MORE INFORMATION ABOUT?

- Program - Activities
- Specific programming and techniques.
- (I may have missed this) Specific auditory skills (order of development)
- I would like to reserve judgement until the whole is complete.
- Behavior problems with hearing impaired children and intervention methods.
- I would like to see tapes of assessment sessions by an expert like Jim assessing children.
- More about ways to pair tactile stimulation and hearing.
- with the SPL child

THE STRONGER FEATURES TODAY WERE:

- of the interactions between the presenter and the group. Also the video presentation added direct information. A picture is worth a thousand words.
- useful information
- It was very informative.
- Excellent content, well explained, carry over to the less severely involved population
- enthusiastic and knowledgeable.
- I gained lots of information.
- materials were real hearing aids/trainers etc that I'd not had experience with operating.
- Of small group and opportunities to interact with presenter.
- I have never had contact with hearing aids and other auditory devices. It was a good experience to get to experiment with them.

- Lots of wonderful and valuable information.
- of the information given which will prove very helpful in dealing with hearing impaired children

I WISH THAT:

- room temperature was constant
- could attend full week
- my schedule would allow me to attend every day.
- the audiologists that work with my kids were as knowledgeable.
- perhaps 2nd day will present more time for programming hints if not need more time for programming.
- Audiologists in this area (who test children in local programs) had received some of the information I have through this session.
- there were hearing impaired teachers to visit and consult with my school.
- I could get more help in my classroom.

GENERAL COMMENTS:

- Great
- Thanks
- much better than hearing information given at my SHIPP training.
- very interesting presentation.
- Session was very beneficial.
- Mr. Durkel was a wonderful presenter.
- Excellent ,
- Presenter was very knowledgeable in his field.

1992 Summer Institute Evaluation Scale

Date: July 16 1992

Topic: Communication
Jim Durkel

= 20

On a scale from 7 (high) to 1 (low) the participants rated the session as:

		Range	Average
1.	The **organization** of today's content was	6-7	6.7
2.	The **objectives** to today's content were:	5-7	6.5
3.	The **work of** the **presenter**(s) today was:	6-7	6.7
4.	The **activities** for today's content were:	5-7	6.5
5.	The **scope** (coverage) of today's content was:	5-7	6.4
6.	My **attendance** today should prove:	3-7	6.4
7.	**Overall**, I consider this training:	5-7	6.5
8.	Need **additional information** about this topic?	Yes = 15	No = 2

MORE INFORMATION ABOUT?

- choice making with profound-severe; integration in a "less than willing" environment.
- need more Van Dyke
- Van Dijk methods
- transitioning kids from objects, to tactile symbols, to pictures.
- communication.
- I don't think you can have enough ideas and examples because each child is different.
- how to assess a kid to better his or her communication needs.
- more of the same, particularly behavior's relationship to communication.
- Assessment Van Dijk Matching with program
- Sign language

THE STRONGER FEATURES TODAY WERE:

- I hope this will help me in the future with working with kids who have communication problems.
- enthusiasm and knowledge of instructor. Practical, useful information I can implement.
- it allowed me to integrate information from the past 3 days to get a "total picture" of client skills, abilities and needs.
- good information, information can be used with all kids. Technical information taken down into language we can understand.

- I have gotten many ideas to use with some of my students to help foster independence and develop language.
- need information on this
- strategies were based on theory.
- it dealt with other forms of communication besides augmented and other Hi-tech ideas.
- Beneficial information, Van Dijk, handouts.
- it dealt with issues and ideas with which I can benefit from.
- Jim did not use a lot of technical jargon - very descriptive and very realistic
- it helped clarify some issues concerning the use of communication devices and systems and how to implement them.
- the speaker was very thorough but very practical in his examples. I learned a lot.
- the presenter had such a wide range of knowledge and experience.
- Stimulated my gray cells.
- I was exposed to totally new information.
- it was extremely informative and was presented with the child's dignity and best interest coming in as a #1 priority.
- it is very helpful in the area that I work.

I WISH THAT:

- I had all this information when I just starting working with multiply handicapped children.
- the special education teachers in my area attended this workshop so my job would be much easier.
- I could get more classroom help.
- less stress (i.e. too much information on Thursday [late])
- everyone understood that all behavior is a form of communication.
- more professionals had the opportunity to attend this training.
- more in-depth training in this area was available.
- more therapists and teachers could hear this presentation so they could do a better job of teaching kids.
- this training was made available to all special education teachers.
- I knew more about communication.

GENERAL COMMENTS:

- Great information very practical and functional.
- There was so much excellent information presented in such a short time it was hard to absorb it all.
- It would be great if this entire workshop was video taped and distributed across the state.
- "Happy Face"
- Thanks!!!
- Very Good
- Great!!!!
- The information on Van Dyke stages, planning routine were extremely helpful.
- It is appalling that people from KSB and KSD are not here. They certainly need this information.
- Why aren't evaluators, therapists and teachers from KSB and KSD here for the week!
- Thanks
- very interesting.
- Good training.

1992 Summer Institute Evaluation Scale

Date: July 17 1992

Topic: Professional Panel
Parent Panel

= 15

On a scale from 7 (high) to 1 (low) the participants rated the session as:

		Range	Average
1.	The **organization** of today's content was	5-7	6.7
2.	The **objectives** to today's content were:	5-7	6.7
3.	The **work of the presenter**(s) today was:	5-7	6.7
4.	The **activities** for today's content were:	5-7	6.8
5.	The **scope** (coverage) of today's content was:	5-7	6.6
6.	My **attendance** today should prove:	5-7	6.7
7.	**Overall**, I consider this training:	5-7	6.7
8.	Need **additional information** about this topic?	Yes = 5	No = 3

MORE INFORMATION ABOUT?

- More information to teachers and therapists on how to integrate therapies and work on a team.
- Supports needed to help people with deaf-blindness live / work / participate more fully in the community; maybe staff from HKNC.
- Combining IEP's (skills) and routines.
- Guardianship -

THE STRONGER FEATURES TODAY WERE:

- very practical, very good presenter.
- it was wonderful in educating me on all that can be done with handicapped and what all their families go through.
- You rarely get to hear things from a parent perspective.
- It reinforced how much parents have to go through for their child.
- of the diversity of participants.
- Parent panels always gives me a better insight of what its like having a child with disabilities. Although one can never truly know how it is for a parent until they've "walked a mile in their shoes".
- it was from the heart reminded me of what is really important in working with children.
- listening to parents and how they feel.
- a.m. - showed what can happed when people work together and are committed.
- it gives love and personal insight.

I WISH THAT:

- Parents and teachers had more opportunities to sit and talk and express their feelings.
- The system didn't fail in so many ways.
- the questions on outline of presentation were provided; it would help me follow along.
- we would continue this type of summer workshop in some fashion.
- So much information - so little time.
- tissues were more plentiful when the North Hopkins H.S. Team was here!!

GENERAL COMMENTS:

- This has been the best workshop that I have ever attended. It has been very helpful.
- I enjoyed it very much! I wish I could've been here the whole week!
- This has been a delightful week. Well organized. Thanks.
- Very good!
- I think four parents would have been sufficient; the last two parents always seemed to be short-changed as their comments were already said.
- Good session. Awesome!
- Thanks again - A useable functional workshop! Wonders never cease!
- Thanks
- This is great!

APPENDIX C

New District Report: Districts Selected During Year V

NEW DISTRICT REPORT:
DISTRICTS SELECTED DURING YEAR V OF THE PROJECT

Five new districts became a part of the Kentucky Systems Change project for the 1991-92 school year. For a variety of reasons, it was not feasible to collect entry level student data. This report will describe the activities each district participated in and technical assistance each district received.

BELL COUNTY

An initial site visit to Bell County occurred in early October; however, two of the three teachers serving students with low incidence disabilities also participated in **SPLASH** during September. SPLASH, conducted by project staff, is an intensive eleven day training that addressed basic district goals, including:

1) Providing technical assistance to the teacher at the high school in developing activities in the vocational area and implementation of a peer tutoring program.

2) Providing opportunities for professional networking with other teachers in the area.

3) Providing training in integrating related services.

In addition to **SPLASH,** teachers participated in the **New District Best Practices Workshop** and the **Eastern Kentucky Teacher Work Group**. The high school teacher visited the program in Jessamine County. Classroom technical assistance was provided to Longjack Elementary Preschool Program, Bell County Middle School and Bell County High School. The Peer Tutoring application for the high school was completed. Training in Integrating Related Services was not accomplished because of the number of days the teachers had been out for other training opportunities. Teachers at the middle and high school levels reported positive gains in integration and in the implementation of community based instruction.

HOPKINS COUNTY

Initial classroom visits in Hopkins County took place in early September. A total of ten teachers serving students with moderate to severe disabilities participated in Project activities. Goals for Hopkins County included:

1) Training and technical assistance to district level "Inclusion Task Force".

2) Training and technical assistance in Integrating Related Services.

3) Provide professional networking opportunities for teachers in the area through a teacher work group.

Ten Hopkins County teachers participated in the **New District Best Practices Workshop** held in Lexington. Two days of technical assistance centered around students who were fully "included" in general education settings. Four Hopkins County teams participated in the **Schools are for All Kids Training.** Two school teams participated in a one day **Integrating Related Services Workshop** held in Hopkinsville for both Hopkins and Christian County districts. Six teachers participated in the **Western Kentucky Teacher Work Group** in which two of the teachers assumed leadership roles.

Pat Murphy, Hopkins County teacher, received the **Kentucky Deaf-Blind Intervention Project's Contributor of the Year** award. In addition, Pat serves on the **Alternate Portfolio Advisory Committee.** Waddill Avenue Elementary School was featured in the Project Newsletter as an excellent example of providing support to a student with disabilities in a general education classroom.

JEFFERSON COUNTY:

Jefferson County, the largest district in the state with over 90,000 students, participated in a variety of project activities in Year V, including:

1) Participating in the **New District Best Practices Workshop** in in Lexington in October.

2) Sending six school teams to the **Level Two Schools Are For All Kids Training** in March. In addition, project staff worked with district leadership staff in a train-the-trainers model for Schools Are for All Kids Training.

3) Extensive work with Project Consultant Dr. Pam Smith in implementing an Integrated Therapy Model in two elementary schools in the district. This included initial training in integrated therapy models for a large group (60+) of district teachers and administrators, more intensive training to central office leadership staff and related services teams from two school sites, meetings with parents in these two sites to discuss benefits and implementation issues, on-site assistance to both sites in implementing a transdisciplinary model, and planning with central office staff to expand the model across sites in the district. Implementation data from the two sites in the *Quality Program Indicator* Integrated Therapy Best Practices are as follows:

School	*Baseline %*	*Ending %*	*% Partially Achieved*
Tulley	15%	66%	38%
Minor's Lane	5%	54%	32%

In addition, Sharon Davis, Low Incidence Coordinator for the District, served on the **Project Advisory Board**, the **Higher Education Subcommittee**, and the **Alternate Portfolio Steering Committee**.

Lelia Morel, a middle school Low Incidence teacher, served on the **Alternate Portfolio Advisory Committee**.

KNOTT COUNTY:

Classroom visits to three teachers in August provided opportunities for teachers to discuss their interests and needs allowing project staff to plan project objectives for the year. Objectives for the year included:

1) Provide training and consultation to the district regarding CBI.
2) Provide opportunities for professional networking with teachers and administrators from other districts.

In addition to the three teachers serving students with low incidence disabilities, three teachers serving students with hearing impairments also participated in project activities. Teachers participated in the three day **New District Best Practices Workshop**, which primarily targeted topics such as: embedding basic skills, integration, integrated related services, professional and student support strategies, community based instruction, and systematic instruction. Many veteran districts also participated, allowing professional networking on an informal basis.

Knott County teachers participated in the **Eastern Kentucky Teacher Work Group** which also included Bell County and Jenkins Independent. This group worked on developing a vision and mission for the work group which included a philosophy for working with students. Teachers shared successes and ideas. Several teachers assumed leadership roles in preparing materials and leading discussions. The work group rated itself highly in terms of meaningfulness and applicability. The work group developed working portfolios of information on report cards strategies and data collection tools.

Knott County High School participated in the **Schools are for All Kids Workshop** held in Lexington. Teachers reported a few more opportunities for integration in regular high school activities as well as access to high school environments.

Project staff reviewed the district CBI manual and made suggestions regarding the refinement of that document. The district received minimal levels of direct classroom technical assistance.

OLDHAM COUNTY:

Oldham County teachers and administrators participated in a variety of project activities including **New District Best Practices Workshop, Schools Are For All Kids Level II Training** (three school teams participated), and administrative planning meetings to map out strategies for moving students with severe disabilities towards their neighborhood schools. In addition, on-site assistance was provided to three schools: Crestwood Elementary, Centrefield Elementary, and Oldham County High School. On-site assistance was targeted towards increased integration opportunities, inclusive education, and activity-based instruction for students with the most severe disabilities (secondary level). Both of the above elementary schools also sent school teams to visit a project elementary inclusive education site during the school year.

Centrefield's Circle of Friends Program was featured in a Project Newsletter, and Sarah Kennedy, High School Low Incidence Teacher, served on both the **Alternate Portfolio Steering Committee** and as a **Regional Leader** for the Alternate Portfolio.

SUMMARY:

All five new districts participated to a high degree in all Project activities. The Eastern Kentucky Teacher Work Group received high evaluations among the participants. Suggestions for improving that included pairing Jenkins Independent with Knott County and Bell County with Somerset to reduce travel and expenses. Efforts were made to include other teachers from districts not in the project; however, no non-project districts participated.

Teachers from all five districts reported gains, especially in terms of integration of students into general education activities. Most students in these districts are included on age-appropriate regular school campuses, though Jefferson County still has one separate school for students with severe disabilities.

APPENDIX D

Alternate Portfolio Teacher's Guide

KIRIS

KENTUCKY ALTERNATE

PORTFOLIO PROJECT

Thomas C. Boysen, Commissioner
Kentucky Department of Education

TEACHER'S GUIDE

Prepared by:
The Kentucky Systems Change Project for Students with Severe Disabilities

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ALTERNATE PORTFOLIO TRAINING OUTCOMES

PARTICIPANTS WILL:

- Identify students eligible to participate in the Alternate Portfolio Assessment Process.
- Identify the rationale and philosophy of the Alternate Portfolio Assessment Process.
- Identify and describe characteristics of portfolio assessment.
- Determine the relationship of Kentucky's Valued Outcomes to the Alternate Portfolio Process.
- Identify required and optional items to be included in the Alternate Portfolio Process.
- Reconcile the Valued Outcomes to sample portfolio items.
- Develop sample portfolio entries for individual students.
- Apply current holistic scoring guide standards in evaluating student portfolios.

NOTE TAKING GUIDE
ALTERNATE PORTFOLIO TRAINING OVERVIEW

ELIGIBILITY FOR ALTERNATE PORTFOLIO ASSESSMENT	**VALUED OUTCOMES, CORE CONCEPTS AND PRINCIPLES**
PORTFOLIO ASSESSMENT ALTERNATE PORTFOLIO RATIONALE AND PHILOSOPHY	**ALTERNATE PORTFOLIO ENTRIES CONSIDERATIONS**
ALTERNATE PORTFOLIO ENTRY TYPES AND CONTEXTS	**ALTERNATE PORTFOLIO HOLISTIC SCORING GUIDE**

ELIGIBILITY FOR ALTERNATE PORTFOLIO ASSESSMENT

CRITERIA FOR DETERMINING ELIGIBILITY OF STUDENTS WITH DISABILITIES FOR THE ALTERNATE PORTFOLIO ASSESSMENT

KDE PROGRAM ADVISORY 5/92

1. Students with disabilities will enter the Alternate Portfolio Assessment when the student's **Admissions and Release Committee** has:

1) determined and verified on the student's individual education plan (IEP) that the student meets all of the eligibility criteria for the KIRIS Alternate Portfolio Assessment.

2) documented in writing in the student's record the basis for its decision, using current and longitudinal data (such as including performance data across multiple settings in the areas of academics, communication, cognition, social competence, recreation/leisure, domestic, community living and vocational skills; behavior observations in multiple settings; adaptive behavior; and continuous assessment of progress on IEP goals and objectives). This will help ensure that the student meets the following criteria:

a) The student's demonstrated cognitive ability and adaptive behavior itself prevents completing the course of study even with program modifications;

and

b) The student's current adaptive behavior requires extensive direct instruction in multiple settings to accomplish the application and transfer of skills necessary for functional application in domestic, community living, recreational/leisure, and vocational activities in school, work, home, and community environments;

and

c) The student's inability to complete the course of study may not be the result of excessive or extended absences; it may not be primarily the result of visual or auditory disabilities, specific learning disabilities, emotional-behavioral disabilities, social, cultural, or economic differences;

and

d) The student is unable to apply or use academic skills at a minimal competency level in natural settings (such as the home, community, or work site) when instructed solely or primarily through school based instruction;

and

e) For eighth and twelfth grade students with disabilities, the student is unable to:

1) Complete a regular diploma program even with extended school services, schooling, program modifications, and adaptations;

and

2) Acquire, maintain, generalize skills and demonstrate performance without intensive frequent, and individualized community-based instruction.

ALTERNATE PORTFOLIO ENTRY CORE VALUED OUTCOMES

CRITICAL FUNCTIONS OF KERA VALUED OUTCOMES AS EVIDENCED THROUGH DOMAIN AREAS

Seventy-five Valued Outcomes identified for **all** children in Kentucky resulted from the Kentucky Education Reform Act 1990 (KERA).

The Alternate Portfolio Advisory Committee, charged with the task of identifying the valued outcomes to be assessed within the Alternate Portfolio Process and totally containing them within a portfolio, looked at the critical functions of each of the 75 Valued Outcomes.The extent to which each could be evidenced for children eligible to participate in the Alternate Portfolio Process resulted in a prioritized subset of outcomes.

Through a process of reconciling student activity schedules and evidencing performance, the Committee initially identified 28 outcomes critical to maintaining the integrity of functional programming for students participating in the Alternate Portfolio Process.

As a result, the 28 identified valued outcomes incorporated into the Alternate Portfolio Process will be evaluated during the first year. The other Valued Outcomes will be incorporated during subsequent years. The following list identifies the 28 Valued Outcomes included in the Alternate Portfolio Process. Statements in italics represent **examples** of the critical function for each outcome.

1. ACCESSING INFORMATION: Students use research tools to locate sources of information and ideas relevant to a specific need or problem. (*Requests assistance)*
2. READING: Students construct meaning from a variety of printed materials for a variety of purposes through reading. *(Reads environmental, pictorial print)*
5. QUANTIFYING: Students communicate ideas by quantifying real, whole, rationale, and/or complex numbers. *(Counts, uses one-to -one correspondence)*
10. CLASSIFYING: Students organize information through development and use of a classification system. *(Sorts or organizes functional items)*
11. WRITING: Student communicate ideas and information to a variety audiences for a variety of purposes through writing. *(Constructs printed, pictorial messages; uses personal signature)*
12. SPEAKING: Students communicate ideas through speaking. (*Communicates basic needs)*
16. USING ELECTRONIC TECHNOLOGY: Students use computers and other electronic technology to gather, organize, manipulate, and express information and ideas. *(Uses adaptive technology to control environment, communicate)*
17. NATURE OF SCIENTIFIC ACTIVITY: Students use appropriate and relevant scientific skills to solve specific problems in real life situations. *(Problem solves in new or novel situations)*
18. PATTERNS: Students identify, compare, and contrast patterns and use patterns to understand and interpret past and present events and predict future events. *(Follows /manages own schedule)*
21. CONSTANCY: Students understand the tendency of nature to remain constant or move toward a steady state in a closed system. *(Predicts next event)*
23. NUMBER: Students demonstrate understanding of number concepts.
30. DEMOCRATIC PRINCIPLES: Students recognize issues of justice equality, responsibility, choice, freedom and apply these democratic principles to real-life situations. *(Makes choices; accepts responsibility for own actions)*

31. STRUCTURE AND FUNCTION OF POLITICAL SYSTEMS: Students recognize varying forms of government and address issues of importance to citizens in a democracy, including authority, power, civic action, and rights and responsibilities. *(Participates in class, school elections, group activities)*
32. STRUCTURE AND FUNCTION OF SOCIAL SYSTEMS: Students recognize varying social groupings and institutions and address issues of importance to members of them, in including beliefs, customs, norms, roles, equity, order, and change. *(Functions effectively in a wide variety of group settings and activities)*
33. CULTURAL DIVERSITY: Students interact effectively and work cooperatively with diverse ethnic and cultural groups.
34. STRUCTURE AND FUNCTION OF ECONOMIC SYSTEMS: Students make economic decisions regarding production and consumption of goods and services related to real life situations. *(Budgets own money; makes purchases)*
37. INTERPERSONAL RELATIONSHIPS: Students observe, analyze, and interpret human behaviors to acquire a better understanding of self, others, and human relationships. *(Initiate s and maintain interactions leading to friendships)*
38. PRODUCTION: Students create products and make presentations that convey concepts and feelings.
45. FAMILY LIFE AND PARENTING: Students demonstrate positive individual and family life skills. *(Contributes to family life, demonstrates appropriate social-sexual behavior)*
46. CONSUMERISM: Students demonstrate effective decision making and evaluative consumer skills. *(Shops comparatively)*
47. PHYSICAL WELLNESS: Students demonstrate skills and responsibility in understanding physical wellness. *(Participates in excercise, diet, self-care activities)*
48. MENTAL AND EMOTIONAL WELLNESS: Students demonstrate positive strategies for achieving and maintaining mental and emotional wellness. *(Expresses feelings, manages stress, maintains relationships)*
49. COMMUNITY HEALTH SYSTEMS: Students demonstrate the ability to assess and access health systems, services and resources available in their community which maintain and promote healthy living for its citizens.
50. PSYCHOMOTOR SKILLS: Students perform psychomotor skills effectively and efficiently in a variety of settings.
51. LIFETIME PHYSICAL ACTIVITIES: Students demonstrate knowledge, skills, and values that have lifetime implications for involvement in physical activity. *(Participates in activities that enhance or maintain physical conditioning)*
52. CAREER PATH: Students demonstrate strategies for selecting career path options.
53. EMPLOYABILITY ATTRIBUTES: Students produce and/or make presentations that communicate school-to-work/post secondary transition skills. *(Participates in transition planning)*
54. POST SECONDARY OPPORTUNITIES SEARCH (JOBS, SCHOOL, MILITARY: Students demonstrate ability to complete a post-secondary opportunities search. (*Compilies a variety of real work experiences, determines preferences, chooses a job placement, accesses necessary supports)*

INTRODUCTION TO PORTFOLIO ASSESSMENT

The Kentucky Educational Reform Act (KERA) outlines six performance goals that are expected of all students upon graduation from Kentucky schools. These goals, framed in measurable terms, will guide the development of curriculum, instruction, and assessment of student achievement.

For the 1991- 92 school year, Kentucky students participated in the writing portfolio process; multiple choice, open response testing in mathematics, social studies, science, and reading; and performance event testing in mathematics, science, and social studies. This year, Kentucky students, in addition to writing portfolios, will develop mathematics portfolios. Students identified by school based admissions and release committees during the 1991-92 school year as being eligible for an alternate portfolio assessment system will develop portfolios during the 1992-93 school year. **The 1992-93 portfolios in the alternate assessment system at the 4th, 8th, and 12th grades will be scored for accountability purposes by October 15, 1993.**

Portfolios showcase student work where learning across life domain activities can be assessed in a comprehensive way. The collection of work will exemplify the goals of KERA, and Kentucky's Preliminary Curriculum Framework. Portfolio assessment represents performance-based evaluation which includes a process for obtaining student information and self-evaluation data. Kentucky's Alternate Portfolio Assessment Process represents a multi-disciplinary approach as opposed to a single curriculum area and models the mathematics and writing portfolios in the use of the holistic scoring guide.

The attached document serves as the training manual and as the guide for the teacher serving children in the Alternate Portfolio Assessment Process. The manual includes eligibility criteria, rationale, assessment considerations, sample student products and productions, and tools for planning student portfolios. All teachers serving students in the Alternate portfolio assessment system must be trained in the use of these materials and in scoring of the portfolios in the alternate system. This guide should be disseminated to all teachers serving students at the 4th, 8th, and 12th (or last year of school) marker years. Storing these materials in a binder/portfolio will allow for addenda that will be sent through the year.

For further information, you may contact **Harold Kleinert (Kentucky Systems Change Project) at (606) 257-3045; Jacqueline Farmer (Kentucky Systems Change Project) at (606) 257-3560;** or call Amy Sosman, Advanced Systems in Measurement and Evaluation, Inc. at 1-(800)-431-8901.

ALTERNATE PORTFOLIO RATIONALE

- Ensures that children with significant challenges will be represented in the accountability system
- Supports an activity that encourages change and growth over a period of time
- Provides other ways for the teacher to look at the effect of programming on individual students, and to make changes in instruction
- Explores a range of critical functioning across life domain areas
- Encourages student choice and decision making in learning as well as evaluation of their own work
- Merges instructional and assessment activities
- Builds in support for meaningful participation

PHILOSOPHY

- Supports a method of evaluation that allows students to demonstrate strengths rather than weaknesses
- Values learning styles and diverse abilities
- Encourages the student to engage in learning that has meaning for him/her
- Provides multiple dimensions for measuring significant progress
- Promotes the vision of enhancing capacities and integrated life opportunities

ALTERNATE PORTFOLIO ENTRIES

A COMPLETE PORTFOLIO WILL INCLUDE:

- **A completed table of contents,** (may represent the student's present mode of communication; written, pictorial, audiotape).
- **A letter to the reviewer** written or dictated by the student (or a collaborative effort of a student and a non-disabled peer) that describes the portfolio and its contents.
- **7-10 entries** that represent the breadth of entries (types, contexts, and domain areas). Each entry must include the original question, task, or problem posed, a name, a title , and a date. Entries must be arranged in the order presented in the table of contents.
- **A student weekly schedule** and description of its use indicating types activities, opportunities for choice and interactions with non-disabled peers.
- **A resume' of job experiences,** both volunteer and paid, accompanied by employer evaluations at marker years 8 and 12.
- **A sample of the student's present mode(s) of communication** and description of its use, which may may be evidenced through the table of contents, letter to the reviewer, or student schedule.
- **A letter from a family member or care/giver** validating the contents of the portfolio.

AN INCOMPLETE PORTFOLIO FAILS TO INCLUDE:

- A table of contents.
- A student letter to the reviewer.
- At least 7 entries (not including the letters).
- A student activities schedule and description of its use.
- A resume' of job experiences for marker years 8 and 12.
- Validation letter from family member or care-giver.

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OTHER CONSIDERATIONS:

- Entries in the category of photographs, audiotapes, videotapes, and computer disks, must be accompanied by a paragraph describing the product and the rationale for its use.
- Student performance data must be graphed and accompanied by a copy of the instructional program as well as a qualitative response from the student, non-disabled peer, and/or family member / caregiver.
- If the table of contents, student schedule and/or the letter of transmittal reflect the student's present mode of communication and its use, then the communication system entry may be optional.
- Entries should reflect participation in the general education writing or mathematics portfolio assessment tasks whenever possible.
- A **Group Product** represents a product completed by a group of students working together. This type of entry must be accompanied by an explanation of the activity and reflection on the student's participation by him/herself and/or peers.
- No more than 2 group products can serve as entries if only 7 items are entered. More group project entries may be included as optional projects in addition to the ten entries. Projects must be listed in the table of contents.
- If there are more than 10 entries (not including the letters), only the first 10 will be assessed.
- Entries must be accompanied by brief descriptions and rationale, and dates.
- Revision of work is encouraged and recommended. Entries should exemplify the **STUDENT'S** best work (highest proficiency level). Entries should be revised, edited, andpolished. This revision should be a *teacher/student* and/or *student/student* collaborative effort.
- Students should begin collecting portfolio entries prior to marker years 4, 8, and 12 so that entries may be revised and the best entries may be selected for entry into the accountability portfolio.

INSIDE COVER OF ALTERNATE PORTFOLIO

NAME________________________

GRADE________________________

SCHOOL________________________

TABLE OF CONTENTS

LETTER TO REVIEWER

Suggested Topics:

- What did you learn from keeping the portfolio?
- What did you think was your best entry? Why?
- Which entry did you learn the most from? Why?

Contexts:

- Should incorporate the student's present mode of communication.
- May be a collaborative effort among the student, non-disabled peers, and/or family.

1. Student weekly schedule (see Protocol page 44)
2.
3.
4.
5.
6.
7.
8.
9.
10.

ALTERNATE PORTFOLIO ENTRY TYPES

Instructional Program Data

This type of entry may extend over a period of time. Graphed instructional program data must be accompanied by a written instructional program (See Protocol p.41). This entry may be accompanied by a student performance video tape and written validation by an inter-disciplinary team which includes the family/caregiver.

Writing/Communication

This entry may include written and/or pictorial materials such as a journal, schedule, address book, resume' or general education writing portfolio task. It may also include transcribed stories dictated by peers and/or reflections about progress written collaboratively by the student, professionals, peers, and family/care-givers.

Investigation/ Discovery

This type of entry is an inductive search for an answer to a question; a guided exploration that leads the student to a generalized performance. This can be accomplished by gathering data, examining models, viewing examples or counter examples, etc.

Application

This type of entry may reflect the use of an adaptation or newly acquired skill in a new or novel setting/situation. Examples may include use of a communication system, purchasing strategy, or other adaptation. This entry must be accompanied by a description of the student's performance in the new settings. This can become a project if multiple new settings/situations are used over time.

Project

This type includes activities which **extend over a period of time (days or weeks)**. Examples might include a fitness routine, shopping project, use of an adaptive switch in a variety of settings for a variety of purposes, use of a purchasing strategy. Examples may be chosen from any of the three domains (vocational, recreation/leisure, personal management). This may also include projects from general education portfolio activities.

A portfolio entry may fall into more than one of the above types.

ALTERNATE PORTFOLIO ENTRY CONTEXTS

The entire portfolio collection should evidence the following contexts:

Integration

An entry that includes or reflects participation with non-disabled peers (this could include an activity within the general education writing or mathematics portfolio), or integration within a community activity.

Functional

The entry has meaning for the student and results in enhanced capacity or independence.

Age-appropriate

The activities included in the portfolio exemplify chronologically age-appropriate products, productions, materials, and environments.

Computer and Other Technology

Activities which involve the use of technology (computers, VCR's).

Assistive/Adaptive Technology

The entry evidences the use of adaptations through assistive devices or strategies that enhance capacity or independence.

Choice Making

The entry evidences student choice and decision making.

Individual Vs. Group Products

Individual

A single student produces this entry whether it is the outcome of a group activity or individual endeavor.

Group

This entry, produced by a group of students working together, must include individual explanation or reflection on the work.

Representative Domain Areas

The entries should reflect products from the following core areas:

Vocational includes school jobs, chores, and volunteer positions to actual paid work experiences in the community.

Recreation/Leisure: includes individual, family, and community recreation/leisure activities.

Personal Management may include activities in the areas of self care, food, space and belongings and/or personal business including community activities.

ALTERNATE PORTFOLIO ASSESSMENT
Holistic Scoring Guide

- The portfolio uses a holistic scoring guide with six levels of descriptors and four performance level descriptions.

- The six levels of descriptors include: performance, support, settings, interactions, types and contexts, and reconciliation of domain areas with core concepts.

- According to the four performance descriptions, a portfolio may be characterized at the novice, apprentice, proficient, and distinguished levels.

- It is unlikely that a particular portfolio will be characterized at all one level. The overall score should reflect the level at which the appropriate descriptors for a portfolio are clustered.

- The workspace/annotations section of the holistic scoring guide should be used to assist the reviewer in analyzing the contents of the portfolio. Commendations and needs may be noted for feedback.

- The worksheet has five sets of bubbles to assist the reviewer in analyzing (1) the breadth of entries; which includes contents, types and contexts, representative domain areas, (2) level of student work; and a (3) holistic score.

    (1) **Breadth of entries**: Filling in a bubble indicates that at least one entry demonstrates that category. An entry may qualify in more than one category of entry type, context, and representative domain areas.

    (2) **Level of student work**: Filling in a bubble indicates the overall quality of student work.

    (3) **Holistic score**: The final portfolio score reflects a holistic judgment of a performance level for the student.

- After analyzing data from the breadth of entries, level of student work, and annotations, the final holistic score will be assigned that best describes student performance level.

- An incomplete portfolio will not be assessed and will receive a score of 1 for accountability purposes.

KENTUCKY ALTERNATE PORTFOLIO

HOLISTIC SCORING GUIDE

	○	○	○	○
	NOVICE	**APPRENTICE**	**PROFICIENT**	**DISTINGUISHED**
PERFORMANCE	Participates in portfolio products, productions	Performs specifically targeted skills in portfolio products, and productions	Initiates performance evidenced in products and productions; evaluates own performance	Plans, initiates own performance in portfolio products and productions; monitors and evaluates own performance
SUPPORT **Accessing Assistance**	Requires formal training support in all aspects of products and performances	Requires moderate support in most products and performances	Requires minimal support from teacher or trainer; may rely more on natural support from coworkers or peers	Uses only natural supports to complete products and performances
SETTINGS Home, School, Community	Participates in products/performance primarily in one setting	Performance occurs in more than one setting	Initiation and performance occurs across settings	Plans and carries out products/performance in a variety of settings
INTERACTIONS	Responds to interactions with teacher, family, and/or only disabled peers	Initiates interations with non-disabled peers	Initiates and sustains interactions with non-disabled peers over time	Has clearly established mutual friendships with non-disabled peers
TYPES AND CONTEXTS	Indicates the use of few types and contexts	Indicates the use of a variety of types and contexts	Indicates a wide variety of types and contexts	Indicates a comprehensive use of types and contexts
RECONCILES DOMAIN AREAS AND CORE CONCEPTS	Limited samples within domain areas reconciled to core concepts	Variety of domain area samples reconciled to core concepts	All domain areas represented and reconciliation to core concepts	Extensive representation of domain areas and reconciled to core concepts

PORTFOLIO CONTENTS O Table of contents O 2 Letters to reviewer O 7-10 entries O Communication O Schedule O Resume	**WORKSPACE**	**ANNOTATIONS**
BREADTH OF ENTRIES	**PERFORMANCE** • Plans, initiates participation/performance in products and productions. Monitors and evaluates participation/performance	
TYPES O WRITING O PROJECTS O INSTRUCTIONAL DATA O APPLICATION O INVESTIGATION/DISCOVERY	**SUPPORT** • Uses only natural supports (non-disabled peers, coworkers) in participation/performance of product/productions.	
CONTEXTS O INTEGRATED O FUNCTIONAL O AGE-APPROPRIATE O COMPUTER / TECHNOLOGY O ASSISTIVE / ADAPTIVE TECHNOLOGY O OPPORTUNITIES FOR CHOICE	**SETTINGS** • Plans, carries out products and productions in a variety of school, home, and community settings	
REPRESENTATIVE DOMAIN AREAS O VOCATIONAL RECREATION/LEISURE O INDIVIDUAL O FAMILY O COMMUNITY PERSONAL MANAGEMENT O COMMUNITY O SELF CARE O FOOD O SPACE/BELONGINGS O PERSONAL BUSINESS	**INTERACTIONS** • Evidences established mutual friendships with non-disabled peers **TYPES AND CONTEXTS** • Utilizes a wide variety of types and contexts **RECONCILES DOMAINS AND CORE CONCEPTS** • Represents samples across domain areas.	

STUDENT VIGNETTES RECONCILING OUTCOMES

RECONCILING INDIVIDUAL STUDENT ACTIVITY SCHEDULES AND PORTFOLIO EVIDENCE WITH CORE VALUED OUTCOMES

Student Vignette High School: Ned

Ned, a 21 year old high school student has a moderate level of disability. He meets and gets along with peers, attends P.E. and vocational classes. He works at the district Pre-school and as a helper in the Agriculture class. He belongs to a swim team. His greatest needs lie in the areas of personal hygiene and vocational skills. He is also working on a budgeting system.

IEP Goals

- Improve vocational skills
- Develop a resume of vocational experiences
- Budgeting weekly purchases
- Improve personal hygiene

Entry Descriptions

Pre school Job Site

Clean breakfast room tables; return trays to the cafeteria; help children brush their teeth with labeled tooth brushes; assist the teacher with the children in play groups with sharing; taking turns; playing fair; using manners; and returning materials to their place

Agriculture Small Power Tool Class

Co-manage the tool room; take in used tools; tag items in need of repair; cleaning and returning tools to bin or peg; assist with computerized inventory; and keep a daily check list

Student Activities Schedule	**Portfolio Evidence**	**Valued Outcomes**
Plans, follows written individual daily schedule	Written daily schedules	Reading, writing, classifying, patterns, constancy
Self-monitoring Hygiene	Hygiene Checklist, graph of checklist data	Patterns, physical wellness reading, quantifying, number
Regular Homeroom Class elections Assemblies Homecoming	Activities journal Student schedule	Democratic principles, reading, structure and function of political systems, cultural diversity, writing, interpersonal relationships
Work at County Preschool (see description)	Self-monitoring checklist, letter from employer, resume', activities journal	Reading, writing, interpersonal relationships, family life and parenting, career path, employability attributes, post secondary opportunities search
Regular P.E. Class	Student schedule, P.E. project, Activities journal	Reading, writing, cultural diversity, interpersonal relationships, physical wellness, psychomotor skills, lifetime physical activities
Community based Instruction Shopping Banking	Budgeting and banking notebook, family grocery shopping project, using instant teller, self monitoring checklist, student schedule	Reading, writing, quantifying, classifying, number, structure and function of economic systems, consumerism
Agriculture Class Tool Shop (see description)	Self-monitoring checkouts, class project, daily activities journal	Patterns, number, classifying, speaking, interpersonal relationships, production, career path, employability attributes
Swim team practice, Monday & Thursday	Lap record, activities journal, strength training record, stroke skill chart	Patterns, number, reading, writing, lifetime physical activities, psychomotor skills, interpersonal relationships

Student Vignette Middle School: Tim

Tim, a twelve year old middle school student, has cerebral palsy and developmental delay. He uses a wheelchair with minimal adaptation for mobility, but requires repositioning in a prone stander daily. He is tube fed twice daily by the school nurse, but also eats/drinks a small amount orally. He operates a computer using a plate switch and 'cause and effect' software. He communicates by smiling in response to question and makes choices using eye gaze and pictures. He is a member of a general education homebase, and spends time with peers during their lunch, and attends general education art class. Peers push Tim to various activities and assist him in participating in class. A circle of friends has promoted the expansion of the quality of peer interactions.

IEP Goals

- Make choices by reaching and/or eye gaze
- Indicate yes/no by smile or scowl
- Operate switch activated items
- Reach, grasp, release in various activities
- Assist in dressing and transfers

Tim's Schedule

STUDENT ACTIVITIES SCHEDULE	PORTFOLIO EVIDENCE	VALUED OUTCOMES
Homebase Class elections Assemblies	Daily schedule, peer report, communication log	Political systems, social systems, interpersonal relationships, cultural diversity, mental/emotional wellness
Selects activities for daily schedule, Organizes picture schedule book	Picture schedule, picture journal with comments from student and peers about preferred activities	Reading, classifying, writing, patterns, constancy, interpersonal relationships
Computer activities using switch (requires prone stand position)	Log of completed activities, instructional program data for switch activation, peer report of assistance required	Using electronic technology, scientific activity, production, interpersonal relationships, psychomotor skills, physical wellness
Art class	Products from art class, Instructional program data for greetings, communication systems, peer report	Speaking, patterns, constancy, structure and function of social systems, cultural diversity, interpersonal relationships, psychomotor skills
Preferred switch activities, music/books on tape (positioned on mat)	Log of preferred music/books, data for switch activation, pictorial representations for communication system	Reading, using electronic technology, psychomotor skills, lifetime physical activities
Lunch Social Interactions	Instructional data greeting peers, use of communication system, videotape of interactions	Reading, speaking
School Job separating supplies with peer	Instructional data, videotape of job, peer review, use of communication system to self-evaluate	Quantifying, classifying, interpersonal relationships, psychomotor skills, production, career path
Community Based Instruction Shopping Bowling	Envelope shopping system, instructional program data, videotape,	Quantifying, reading, numbers, structure and function of economic systems, consumerism, psychomotor skills, Lifetime physical activities

RECONCILING STUDENT ACTIVITIES TO VALUED OUTCOMES
PORTFOLIO EVIDENCE

STUDENT ACTIVITIES SCHEDULE	PORTFOLIO EVIDENCE	VALUED OUTCOME

Student Vignette Elementary: Joshua

Joshua, an 8 year-old student with multiple disabilities, spends the majority of his day (75%) integrated in a primary school classroom. Joshua gets around in a wheelchair with help from friends in his class. He uses eye gaze to choose preferred items with a picture communication system. He uses a switch to activate preferred toys and appliances. One hour a week, he purchases preferred items using an envelope budgeting system.

IEP Goals:

- Choosing preferred items with an eye gaze picture system
- Identifying belongings with own printed name
- Vocalizing to request assistance and respond to greetings
- Extending reach and grasping items in the context of activities with typical peers
- Maintaining head control and orientation to speaker/activity for five minutes

Student Activities Schedule	Portfolio Evidence	Valued Outcomes
Arrival Greetings Maintain head control		
Use eye-gaze to select preferred activities in daily schedule		
Specials (Music, Art, P.E.)		
Cooking (using switch to activate appliances)		
Community-Based Instruction making purchases		
Lunch with Peers		
Recess with Peers		
Box it and Bag it Math		
Social Studies Thematic Unit		
Learning Centers		
Dismissal		

Student Vignette Elementary School: Michelle

Michelle, a nine year old diagnosed with Down syndrome, meets and gets along with peers, takes care of basic self-care needs independently. She attends regular fourth grade class for thematic units, learning centers, and 'specials' (Art, P.E. and Music). Her greatest needs lie in the areas of communication in asking for help; making appropriate comments; reading and responding to environmental print; and basic mathematics operations. She uses a calculator to consecutively subtract purchases during community based instruction.

IEP Goals:

- Reading and responding to environmental print
- Making appropriate comments, requests, ask for help
- Counting objects and using basic mathematics operations
- Budgeting purchases using consecutive subtraction

Student Activities Schedule	Portfolio Evidence	Valued Outcome
Arrival		
Schedule Individual Activities		
Thematic Units		
Learning Centers		
Specials (Art, P.E., Music)		
Math		
Lunch		
Community Based Instruction Consecutive subtraction Purchasing		
School Library Helper Shelves books Sorts cards		
Dismissal		

Student Vignette Middle School: Caran

Caran, a 14 year old middle school student diagnosed with autism, follows a picture schedule, participates in general education art class, works in the school office delivering messages to teachers with a peer, and keeps a daily journal on a computer. She needs to work on reading environmental print, budgeting money for purchases, and matching times with scheduled activities.

IEP Goals:

- Read and follow daily schedule
- Perform school job
- Read functional materials
- Improve social interaction skills with peers

Student Activities Schedule	Portfolio Evidence	Valued Outcomes
Plan and read daily schedule		
Homebase		
Art Class		
School Job delivering messages		
Community Job Public Library		
Community Based Instruction Making Purchase Budgeting money Ordering, paying in fast food restaurant		
Listen to books on tape		
General Education Activity Period		
Review daily schedule Write journal entries on computer		

Student Vignette Middle School: Kate

Kate, a 13 year old female has Down syndrome. She reads on a fifth grade level with comprehension at the 3rd grade level. She goes to regular homeroom, social studies, and related arts independently. She works in the community at Dairy Mart, and volunteers at the nursing home. Kate grocery shops for her family but has difficulty with money skills. Peer tutoring has been a positive experience and being with other students is very important to her.

IEP Goals

- Increase independence at worksites
- Budget money for grocery items
- Pay for purchases with the correct dollar amount

Student Activities Schedule	Portfolio Evidence	Valued Outcomes
Arrival		
Plan and write daily schedule		
Homeroom		
Work at Dairy mart		
Social Studies Class		
Community Based Instruction Paying for purchases Budgeting money		
Related Arts Class		
Volunteer at Nursing home		

Student Vignette High School: Ann

Ann, an 18 year old high school student, has autism. She communicates with others using pictures, signs, and Facilitated Communication. She purchases grocery items and her favorite fast food lunch using an envelope budgeting system. Work experiences include facing shelves at the grocery store, delivering messages, and vacuuming. She requires supervision for most activities. An informal network of friends help in providing support in some her favorite activities: music keyboarding class, physical education, and facilitating communication on a computer keyboard.

IEP Goals:

- Use pictures/symbols to schedule daily activities
- Respond to pictures/symbols in natural environments
- Improve independence in vocational settings
- Choose the best buy in making purchases
- Perform exercise routines, play team games

Student Activities Schedule	Portfolio Evidence	Valued Outcomes
Home Training Showering, Dressing Prepare breakfast Wash clothes		
Arrive School Prepare schedule		
P.E. Class with Peer tutor		
Community Based Instruction Banking Grocery Shopping Walmart shopping Fast food		
Job at Library Vacuuming		
Lunch with peers McDonalds (Thurs)		
Budgeting money		
Music Keyboarding Class		
Deliver Messages in School		

Student Vignette High School: Jay

Jay, a 17 year old young man with deaf-blindness, loves to be outside and has a great memory. He has been described by those who know him as gentle, persistent, and hard working. Jay uses a calendar box to schedule this activities and make choices. He uses a timer and bell to identify the concepts of now and wait. He is learning to communicate "stop" and "no" to discontinue an activity. He works in the class Balloon Factory as the ribbon cutter.

IEP Goals

- Initiate interactions with signs across domains
- Use calendar box with Braille words and numbers
- Improve the use of right hand

Student Activities Schedule	Portfolio Evidence	Valued Outcomes
Uses object shelf to schedule activities		
Prepares and cleans up breakfast		
Works in school patio garden and greenhouse		
Community based instruction making purchases		
Lunch with peers		
Works in the Balloon Factory with student council		
Attends P.E. Class		
Walks on track with peer		
Dismissal		

SAMPLE ALTERNATE PORTFOLIO PRODUCTS AND PRODUCTIONS

The following samples may be used as prompts by students as possible alternate portfolio entries. These activities, designed by the alternate portfolio advisory committee, should help teachers draw on their own experiences and ideas. These suggestions should not be considered an all encompassing list, but rather as a starting point in thinking about possible products. When incorporated into the portfolio, these activities will necessarily be expanded and adapted. We would appreciate any feedback that you may be willing to share regarding the usefulness of the items mentioned or different items which have worked well for you and your students.

Note that in choosing instructional activities as possible portfolio entries, the activity should allow the student to show a more efficient or sophisticated process, an insightful interpretation, or a generalization of learning.

SAMPLE PORTFOLIO PRODUCTS FOR GRADE 4

INVESTIGATIONS/DISCOVERIES

•Using a vertical number line, determine the cheaper of two or three items. Explain your choice.

•Investigate the number of coin combinations that will purchase your favorite vending machine snack. Use money stamps or replicas to show the combinations.

•Apply the use of a switch to a variety of electronic toys appliances. Which ones work? Which ones do you like the best? Which ones don't work?

WRITING/COMMUNICATION

•Write, dictate, select pictures that represent a daily schedule or journal of events and activities. A description of schedule use and evaluation of performance should be included.

•Write, dictate, select representative pictures of language experience stories. Include a personal word or picture bank of new words used in the stories.

•Use an identifiable stroke (or rubber stamp) for writing name, identifying belongings, sending cards and letters. Include samples of labeled items and evaluation of performance.

•Construct a photo journal of daily routines, special events. Write captions for the pictures. Include your personal dictionary or word list.

APPLICATIONS

•Apply the use of new communication pictures /symbols outside the classroom, (on the playground, at lunch, at the store). Include evaluations of using the new pictures. Keep a dictionary of symbols as they are added to the system.

•Apply the use of a purchasing strategy (calculator, envelope system) to purchase small items (snack). Evaluate the use of the purchasing system. Keep track of money spent.

- Apply the use of an adapted switch to activate preferred toys, computer, appliances, single-loop tape. Keep a photo book of items activated by switch and select your favorites.

- Manage school job sequence cards, daily schedule, weekly calendar. Include samples of cards, schedules, calendars. Evaluate your performance.

- Read daily schedules, school lunch menus, bulletin boards, and signs. Keep a card file of words you can read.

PROJECTS

- Develop a collection of stories written or on tape. Write, dictate and/or illustrate special stories from the collection. Present selected items from the collection to a small group.

- Budget an allowance for a special purchase. Compare prices at various stores, select the best buy. Illustrate your choice.

- Develop a picture book of school jobs and responsibilities for the year. Write /dictate or illustrate your favorite school job.

- Develop a written or pictorial collection of nutritious snacks. Prepare written or picture recipes of your favorite nutritious snacks to go with the collection.

- Develop a self-improvement program (e.g. dental care). Keep records of tooth brushing, flossing, using mouth wash on a calendar or chart. Include tooth brushing performance data. Make a collage of the important aspects of dental care.

- Keep a personal dictionary (written/pictorial) or word bank of frequently used words/pictures.

SAMPLE PORTFOLIO PRODUCTS FOR GRADE 8

INVESTIGATIONS/DISCOVERIES

- Using ads from the newspaper, decide which store, e.g. grocery, clothing, toy, seems to be the best place to shop. (This could be a project if data is kept over time).

- Use a calculator to consecutively subtract grocery items from a budgeted amount. Could you purchase everything on your list? Did you have enough money?

WRITING/COMMUNICATION

- Write, dictate, use pictures to illustrate a log of daily or weekly work activities. Evaluate your performance; include employer evaluations. Collect information about jobs you might like to do. Organize the information into a notebook.

- Write or dictate cards, and/or letters to a pen pal or special friend.include samples of letters, personal dictionary and address book.

- Write or dictate personal information on forms and applications. Keep records of forms filled out and for what purposes. Include sample forms and applications. Evaluate own performance.

- Write, dictate, use pictures to develop a telephone/address book of friends and family

- Write, dictate use pictures to develop shopping lists for various shopping activities. Keep a word, picture bank of shopping words or pictures. Keep track of new words.

APPLICATIONS

- Plan menus, shop, and prepare simple meals. Adaptive switches/devices may be used to assist in preparation. Prepare sequence cards or write down the preparation steps. Evaluate and have others evaluate the meals.

- Budget money for weekly activities, personal needs. Keeps records of money spent, saved, and current balance.

- Use a calendar to keep track of birthdates, special events, appointments. Include descriptions of how and when the calendar is used. Evaluate your use of the calendar and include samples of use.

- Develop skin/hair care routine. Chart your progress. Collect information about skin and hair care. Organize the information into a skin/hair care notebook.

- Take up a sport(swimming/soccer) . Keep a chart of practice hours, new skills learned. Collect information about the new sport. Organize information into a notebook.

PROJECTS

- Keep weekly log/journal of work activities. Construct a resume of job experiences, both paid and volunteer. Evaluate your own performance and set goals for the next week.

- Coordinate the use of the calendar and address book. Keep track of birthdays and special events. Send cards, letters to friends and family. Include your personal dictionary.

- Develop a book or card file of favorite recipes. Keep sample shopping lists and approximate costs for each recipe.

- Care for a pet/plant. Keep a journal of activities, records of feeding, growth, and habitat management. Identify and budget money for food and supplies. Collect information about the pet/plant; organize information into a notebook.

- Develop a recycling project. Determine items to collect, procedures, and cost. Keep a log of number of items collected, amount of time spent, and additional money spent.

SAMPLE PORTFOLIO PRODUCTS GRADE 12

INVESTIGATIONS/DISCOVERIES

- Investigate the use of various switches as they apply to vocational tasks. Which ones worked best? What jobs were you able to perform? Which ones didn't work so well? Why?

- Use the following materials to compare prices for family grocery items: weekly advertisement, calculator, and vertical number line. Which store has the best buys? Which store has the highest prices? How much money did you save?

- Conduct a survey of employers. Ask them questions about the skills and work habits of their employees. What skills/habits do they consider important?

- Shadow workers in at least five different jobs. What kinds of things did they do? Which job was your favorite? Which job would you like to try again?

WRITING/COMMUNICATION

- Complete a resume of at least four community jobs, either paid or volunteer. Include letters of recommendation and sample employer evaluations. Identify career goals and a plan for accomplishing those goals.

- Keep daily/ weekly/ monthly schedule of activities and address book/ telephone list. Record plans of activities with non-disabled peers, friends, and family in a journal. Evaluate your use of the schedule.

- Maintain a "reading list" of favorite books or books on tape, and/or videos. Write/dictate a brief description of the story and why you like it.

- Keep weekly grocery and shopping lists, meal plans, recipe files. Organize them into a notebook. Include picture/word bank of new words.

APPLICATIONS

- Keep a monthly budget of expenses. Maintain a checking account or other banking system. Evaluate your performance in using the budget.

- Participate in a regular fitness, personal care, and/or self-management routine. Collect information about the routine and organize the information. Chart your progress and evaluate your performance.

- Develop a new hobby (floral design or play a musical instrument) . Collect and organize information about your hobby. Write down expenses and determine the costs of your hobby.

PROJECTS

- Participate in a school or community fund raising project. Keep a record of money raised, time spent, and calendar of activities related to the fund raising effort.

- Participate in a community volunteer project. Keep a record of events and volunteer hours. Include certificates, letters of commendation. Evaluate your participation

- Develop a complete fitness routine. Keep records/logs of progress and new skills learned. Collect and organize information about your routine and determine the cost of your program.

- Conduct a post high school job/education search. Collect and organize information, record letters sent meetings held, and develop a list of contact persons. Add those to your personal address book.

GLOSSARY OF TERMS

PORTFOLIO: A collection of **STUDENT** products and productions that evidence educational experiences, student choice, and evaluation of learning.

ACCOUNTABILITY PORTFOLIO: The specific products and productions representing the student's best work that will be evaluated for school accountability purposes.

HOLISTIC SCORE: The most consistent level of student performance identified by the six levels of descriptors.

BREADTH OF ENTRIES: The types of entries,their contexts represented and entries representative of domain areas.

PERFORMANCE: The extent to which the student actively demonstrates the target skill in portfolio products and productions.

SUPPORT: The extent to which the student accesses assistance that allows performance in developing products and productions.

SETTINGS: The extent to which student performance in products and productions occurs across home, school, and community.

INTERACTIONS: The extent to which the student interacts with same age non-disabled peers

TYPES AND CONTEXTS: The portfolio includes representative samples of writing/communication, applications, investigations/discoveries, projects, and instructional programs that reflect integrated, functional, age-appropriate, programming that also includes assistive/adaptive technology and provides opportunities for choice.

RECONCILES DOMAIN AREAS AND VALUED OUTCOMES The portfolio entries which represent student products and productions within domain areas also evidence valued outcomes.

STUDENT SCHEDULE: A required portfolio entry that describes the student's typical day or week. See example (p. 41)

INSTRUCTIONAL PROGRAM DATA: Data representing systematic instructional programming as evidence of student performance in products and productions. See example (p. 44)

PRODUCTS AND PRODUCTIONS: Evidences of student work that result from participation and performance in learning activities.

PROTOCOL FOR EVIDENCING PERFORMANCE THROUGH VIDEOTAPE

Individual Videotape Profiles Protocol

Rationale: According to Blaha and Wiley (1992) videotape profiles can provide objective, clear, and accurate pictures of students' abilities and preferences by illustrating activities, routines, and strategies for instruction and support. Permanent videotape records provide evidence of student performance in products and productions.

Preparation: Blaha and Wiley(1992), recommend the following procedures:

- Gather information from all significant parties; student, family, teachers, related service providers, or human service agencies in planning the goals and content of the videotape.
- Carefully arrange the environment, making sure that all materials are gathered and in place before taping begins.
- Ask someone to operate the camera while you work with the student. Make sure that this person can operate video-tape equipment, and that the equipment is in good working order before the taping begins.
- The novelty of taping might disrupt the routine, or distract the attention of the student. The camera operator should be as unobtrusive as possible. The more often taping occurs, the less novel it becomes for the student.
- Permission should be obtained from parent, guardian, or student before taping. If peers appear in the tape, permission must be obtained from them as well.
- Videotape may be especially intrusive in community settings. Be sure to let businesses and other community sites know why you are taping and secure permission from someone in authority prior to taping.

Method:

- An evaluation script should be used to plan and develop the profile. It should be kept with the tape, acting as a record of contents.
- Activities should be presented in consistent order from tape to tape, and within sections outlined in the protocols. The tape may require some editing. Basic editing can be accomplished with two VCRs.
- The total time of the profile is important. Do not include non-essential information. Twenty or thirty minutes of tape can convey much information.

- The content of the profile should be vignettes of the student doing activities, not professionals talking. Comments should be made in writing. All aspects of the activites should be demonstrated by the student.

- Explanation that occurs as a natural part of the interaction may be done while taping. Other types of explanation should be conducted as a voice-over after the tape is complete.

- Out of respect for the student's privacy, certain aspects of dressing, toileting, and bathing require privacy and should not be videotaped.

PROTOCOL FOR EVIDENCING PERFORMANCE THROUGH INSTRUCTIONAL PROGRAM DATA

INSTRUCTIONAL PROGRAM FORMAT

STRUCTURAL INFORMATION

Environment: Foodtown
Activity: Grocery Shopping
Student: Ann
Teacher: Jacqui
Day of the Week: Tuesdays 10:10-11:15
Transportation School bus
Materials: Picture/symbol list; Money envelope

PROCEDURES

Preparation:

Meet Ann at her locker. Prompt her to look at the picture on her schedule to remind her that she is going to the store. Prompt her to get things she will need from her locker (jacket, purse,). Meet in the classroom.

Before sitting down, Ann will need to get her shopping booklet with her money envelope and shopping pictures. She will select the picture of the item that she will buy.

Review and Introduction:

Have Ann check her envelope to see that she has money. She will be responsible for handling her own money. Check the data card from the last trip and inform the student of what she did well(e.g. "Ann, you found your item"). Then point out one or two things to work on this time.

Travel to the Store

(Check seat belt plan)

Grocery Shopping:

Ann will use a shopping cart. She will need to move over to the first aisle to get organized. The shopping strategy should:

1. Go down the first aisle.
2. Review the entire list.
3. Scan the aisle and review the sections. You'll need to prompt "This is the produce section. Anything on your list from here?"
4. Stop, if that section contains something on the list. If not, move on.
5. Repeat procedure for each aisle.

Encourage Ann to look at people and smile to return their greetings.

Instruction Cues:

Partial physical(PP) prompt or **full physical prompt(FP)**: The teacher places his/her hands and/or body in direct contact with the student's body and puts the student through the correct performance of a response. **Gestural (G)**: The teacher moves his/her hands or body to suggest a response. **Verbal (V)**: The teacher addresses statements or words in the student's primary communication system directly to the student to assist a response. **Modeling (M)**: The teacher demonstrates the response for the student, requiring the student to repeat the response.

Return to School

Ending the Lesson:

Ann should put her materials away. Review the lesson. Highlight successes. Have the student "chart" her success (e.g. Check off the successes on her chart). Ask student reflection questions: "Did you find your item?; Did you need a lot of help?; How many "successes" did you have? Did you work hard? Did you like the activity?"

SAMPLE DATA COLLECTION CARD

SKILL / DATE	9/8							
1. Enter Store	+							
2. Obtain cart	+							
3. Scan aisles/sections	- PP							
4. Check list for item	- G							
5. Repeat scanning	- V							
6. Select item	- V							
7. Move to checkout	+							
8. Wait in line	+							
9. Pay for item	+							
10. Leave store w/item	+							
Total (+) (-)	6/4							

STUDENT PROGRESS GRAPH

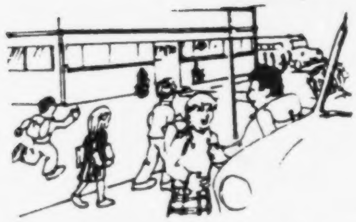
(Student may color in, mark off number of successes)

Steps							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
Date							

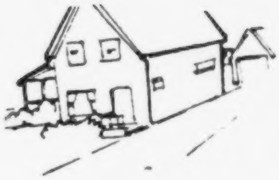
PROTOCOL FOR DEVELOPING STUDENT ACTIVITY SCHEDULE

SCHEDULE FOR ANN

7:55

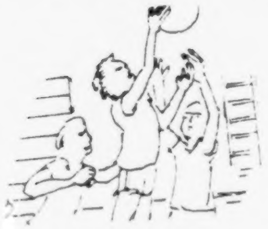


SCHOOL (MWF)

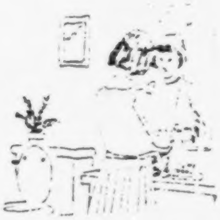


HOME (T TH)

8:15

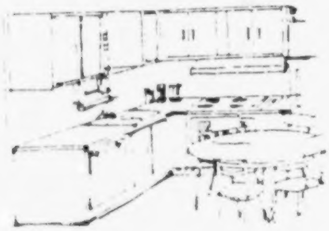


P. E. (MWF)

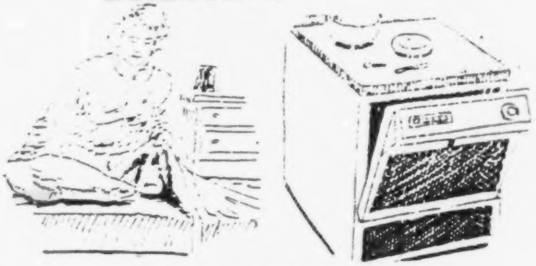


DRESSING

9:10

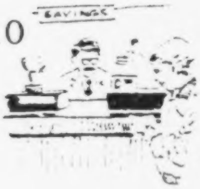


HOME - EC



HOME CHORES

10:10



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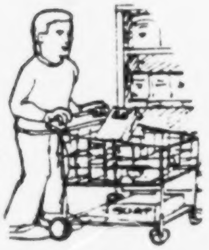

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WAL-MART

WALMART
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MCDONALDS
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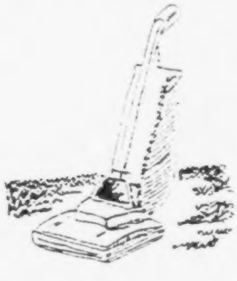
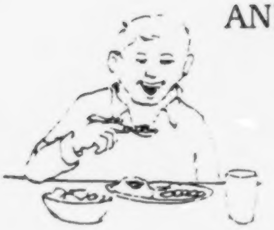


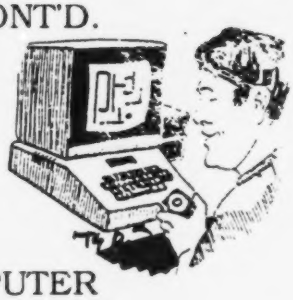
WORK VACUUMING (F)

ANN'S SCHEDULE CONT'D.

11:05

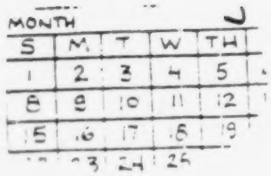


LUNCH (FRIEND)



COMPUTER
FACILITATED
COMMUNICATION

12:45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SCHEDULING
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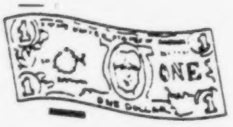

BUDGETING
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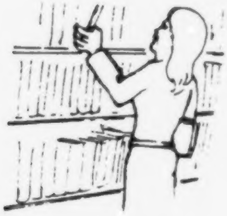
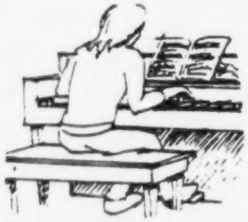


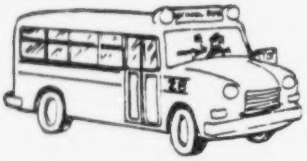
LIBRARY
W F

1:50



MUSIC KEYBOARDING

3:00



DISMISSAL

Description of Schedule Use:

9/26/92

Upon arrival at school, Ann gets her schedule book and with assistance from a peer checks the pictures and makes changes according to the day. Using a combination of environmental cues (high school bell schedule) and the pictures, Ann points to the activity that comes next on the schedule. Choices of activities may appear as well in the picker schedule. In that case, she makes a selection. Upon making the selection, she goes immediately to that activity. The process repeats with the completion of each activity.

PROTOCOL FOR DEVELOPING STUDENT RESUME'

Leslie Beach
9870 Paradise Blvd.
Nicholasville, KY 40356
(606) 885-1234

EXPERIENCE	
September 92 to present	Wither's Memorial Library Nicholasville, Kentucky Custodian Assistant Vacuum meeting room, straighten carpet squares, clean glass cases, windows and doors, dust shelves and place all returned books to rack
October 1990 to May 1992	Fitch's IGA Wilmore, Kentucky Stock Clerk Face shelves, return misplaced items to correct area and put up stock
October 1989 to May 1990	Brookside Baptist Church Nicholasville, Kentucky Custodian Assistant Vacuum sanctuary, straighten hymnals in rack, clean restrooms and clean glass doors
EDUCATION	Jessamine County Senior High Nicholasville, Kentucky
REFERENCES	Available upon request

JESSAMINE COUNTY HIGH SCHOOL
EMPLOYER EVALUATION/VOCATIONAL PROGRAM

Date:____________________

Name of Worker:__________________________

Name of Business/Organization:________________________

Name of Supervisor:______________________

1. Were you satisfied with the quality of work our student did for your organization/business?

   YES NO

   COMMENTS

2. Did the worker have regular attendance?

   YES NO

   COMMENTS

3. Was the worker on time at least 90% of the time?

   YES NO

   COMMENTS

4. Did the worker call if he/she could not come to work?

   YES NO

   COMMENTS

5. Was the worker dressed appropriately for work?

   YES NO

   COMMENTS

STUDENT WORK SURVEY

STUDENT'S NAME ________________ DATE ________________

WORK SITE ________________

1. DID YOU LIKE YOUR JOB?
2. WHAT DID YOU LIKE BEST ABOUT YOUR JOB?
3. DID YOU ARRIVE AT WORK ON TIME?
4. DID YOU GET OFF WORK AT THE REGULAR TIME?
5. DID YOU UNDERSTAND THE DIRECTIONS GIVEN TO YOU BY YOUR SUPERVISOR?
6. WHAT DID YOU DO AT WORK TODAY?
7. DID YOU HAVE EVERYTHING YOU NEEDED TO DO A GOOD JOB?
8. WERE YOUR SUPERVISOR AND CO-WORKERS FRIENDLY AND HELPFUL TO YOU?
9. DID YOU GET A BREAK?
10. DID ANY STRANGERS BOTHER YOU AT WORK TODAY?

KDE Alternate Portfolio Training Calendar
1992-1993

	1992
Alternate Portfolio Advisory Committee Meeting	July 6-8
Alternate Portfolio Advisory Committee Meeting	August 11
Region 3 Training Leader Training	Sept. 16
Regional Leader Training	Sept. 28
Region 3 Training Executive West Louisville	Sept. 25
Region 5 Training U of K Student Center Lexington	Oct. 9
Region 1 Training Executive Inn Paducah	Oct. 12
Region 2 Training Greenwood Executive Inn Bowling Green	Oct. 13
Region 7 Training Greenbow State Park Greenup	Oct. 19
Region 8 Training Holiday Inn Prestonsburg	Oct. 23
Region 4 Training Holiday Inn Covington	Oct. 30
Region 6 Training Cumberland Falls State Park Corbin	Nov. 7
Teachers Collect Portfolio for Accountability	November - May 15
	1993
Regional Leaders Update Meeting	Jan 15
Advisory Committee Review	Jan. 30
Regional Leaders Update	March 1
Portfolios Collected for Benchmark Purposes	May 15
Lead Teachers identify Benchmark Portfolios	June 1993
Advisory Committee Determines Scoring	July 1993
Teacher Training Portfolio Scoring	Aug. - Sept.
District Level Scoring	Oct. 1993

APPENDIX E

Alternate Portfolio Steering Committee Meeting Agendas and Evaluation Summaries
Alternate Portfolio Regional Leaders (State-Wide) Agenda and Evaluation Summary

Alternate Portfolio Advisory Committee
July 6 - 8, 1992

Hyatt Regency, Lexington

Monday, July 6

1:30 Introduction to Alternate Portfolio

1:50 Slide Presentation on Students

2:00 Quick Write

2:10 Valued Outcomes Activity

2:40 Break

2:50 Portfolio Overview

- Characteristics of effective portfolios
- The portfolio process in Kentucky
- Specifics of the alternative portfolio (including the eight principles)

3:30 Shared Thoughts Activity

4:00 Quick Write on Most Difficult Issues and Discussion

4:30 Overview of Day 2 and Day 3

4:45 Adjourn

Tuesday, July 7

8:30 Defining the Ultimate Outcomes: What Does It Look Like At the End of School? (Student Performance *and* Necessary Supports)

9:00 Applicability and Prioritization of 75 Valued Outcomes for Target Population (Small Group Work): Goal One Outcomes

9:45 Goal Two Outcomes

10:45 Break

11:00 Goal Three through Goal Six Outcomes

12:00 Lunch

1:00 Student Case Study 1 (Elementary, Middle and Secondary Working Groups) - Identifying Potential Portfolio Tasks Based on Critical Outcomes

1:45 Discussion of Portfolio Tasks Across Ages (Large Group)

2:00 Student Case Study 2: Consideration of Portfolio Tasks (Small Groups)

2:30 Discussion of Portfolio Tasks for Second Student Case Studies (Large Group)

2:45 Break

3:00 Considerations on Developing Standards/Scoring Rubric

3:15 Development of Potential Standards and Scoring Rubric for Sample Portfolios (Small Group)

3:45 Large Group Discussion on Standards Across Tasks

4:15 Identification of Further Issues for Discussion and Clarification on Day 3.

4:45 Adjourn

Wednesday, July 8th

8:30 Consideration of Relevant Issues (including):

- Refinement of Standards
- Clarity of Eligibility Criteria
- Measuring Student Growth (Baseline Measures)
- Relationship to IEP
- Expanding Portfolio in Successive Years to Larger Subgroups of the Valued Outcomes
- Role of Student in Selection and Evaluation of Portfolio Tasks
- Role of Parents/Guardians in Process
- Teacher and Administrative Training Issues
- Scoring and Reliability Issues
- Other Key Issues as Identified by the Committee

2:15 Action Steps and Wrap-Up: Preparation for Next Meeting in August

3:00 Adjourn

Proceedings of the Alternate Portfolio Advisory Committee Meeting of July 6 -8, 1992

Monday, July 6:

The meeting opened with introductions, and an explanation of the committee's task in providing guidance for the development of the alternate portfolio. Harold Kleinert presented a brief slide presentation of the range of challenges and considerations that will need to be addressed in designing a portfolio for students who qualify for the alternate system. Rich Hill and Scott Trimble presented information on the portfolio development process in Kentucky, and Jacqui Farmer presented an overview of general characteristics of student portfolios. Harold presented the eight KDE principles for the development of the alternate portfolio.

Within small groups, committee members brainstormed critical outcomes that we value for students with moderate to severe disabilities (who will make up the great majority of students in the alternate portfolio), as well as the crucial issues that will have to be resolved.

Tuesday, July 7:

The morning's initial activity was to generate the end or 'school-exit' outcomes for students in this population. This activity served as the starting point for the major task of the day, which was to determine which of the seventy-five KDE valued outcomes were high priorities for the students in the alternate portfolio system. The committee was divided into three working groups for this task: the primary/elementary group (Grade 4); the middle school group (Grade 8); and the high school/secondary group (Grade 12). Each group considered each of the seventy five valued outcomes in turn. Each outcome was considered in terms of: a) its *applicability* or *relevance* to these students; b) its *priority* for these students; and c) specific behavior or task *modifications* that could be made to document that students in the alternate portfolio were achieving that outcome. The results from each group were compared for each of the 75 outcomes to reach a group consensus on the most important outcomes. Of the full 75 valued outcomes, 41 were identified as high priority for alternate portfolio students (see the attached handout). Several members of the Advisory Committee expressed concerns about whether all 41 of these outcomes were applicable to *all* of the students in the alternate portfolio system. This concern was greatest for students with the most severe disabilities.

The Advisory Committee then considered the subset of the 75 valued outcomes that are *currently* being assessed (or will be assessed next year) for students in the regular assessment process. A total of 49 outcomes are included in this subset. Of these 49 outcomes currently being assessed for regular education students, 25 of these had been identified by the Advisory Committee as high priority outcomes for students in the alternate portfolio system. The Advisory Committee decided that the alternate portfolio should initially assess these 25 outcomes, plus two *additional* outcomes not included during the first two years in the regular assessment system: Outcome 12 (*Speaking or Communicating*) and Outcome 16 (*Using Electronic Technology*). These two additional outcomes were included because their critical implications for students with in the alternate portfolio. Thus a total of 27 outcomes were identified for the initial alternate portfolio.

Using these 27 outcomes, the Advisory Committee three working groups each then considered a 'case study student portfolio contents. Each group identified how each of the outcomes pertained to their case study student, and how that outcome could be documented through a portfolio task/activity or product.

Wednesday, July 8:

The Advisory Committee again broke into its three working groups to consider a second 'case study student for each age group. Each group was given a 'case study student whose needs and challenges were considerably different than the student the group had considered the day before. Jacqui noted that an efficient way for planning the portfolio is to consider how each of the outcomes are already "embedded" into the context of the student daily schedule, and then identifying additional portfolio tasks that "fill in the gaps".

Considerations of portfolio contents for each student, and especially documentation of each outcome for every student, lead into a lively (to say the least!) discussion of whether or not all students should be held accountable for all standards and whether or not the IEP took precedence over the valued outcomes. The consensus of the group was that, to the maximum extent possible, all students should be 'held' to the same valued outcomes. Nancy LaCount noted that the IEP does *not* take precedence over the valued outcomes, but rather the IEP is a one-year prioritization of instructional targets individualized for a specific student.

This discussion led into the issue of standards for scoring the portfolio process. Judy Tabor presented the group with the math portfolio standards that have recently been developed, and Harold shared the writing portfolio standards. There was several favorable comments about the scoring rubrics and the format of the math standards ("Novice, Apprentice, Proficient, and Distinguished"), and questions as to whether such a format could be used with the alternate portfolio.

The committee considered the dimensions for scoring, and agreed that a critical piece of the outcome data was not only whether or not the student could *perform* a behavior or skill that documented that outcome for that student, but whether the student could perform that skill across relevant regular *school* and *community settings*, and especially in the context of *interacting* with his/her *typical age peers*. Other critical dimensions included whether or not the activity used to document that outcome was itself *functional* (e.g., meaningful and valued by typical age peers) and *age-appropriate.* Scott noted that we would want to have some way for measuring *growth* in specific behaviors over time, and that a growth dimension needs to be added to the scoring rubric.

Sharon Davis suggested that a natural *organizer* for the portfolio process could be the four domains: practical living, community functioning, vocational, and recreation/leisure. There was considerable discussion as to whether the four domains should be themselves be included as scoring dimensions for the portfolio, or whether the domains should be embedded into broader scoring rubrics that generalized across all tasks.

Finally, the Advisory Committee identified the next tasks that had to be done, and assigned responsibilities for each. The *Kentucky Systems Change Project* staff will work on the scoring standards and rubric, will consider how each of the prioritized outcomes can be applied to all students (especially students with the most severe disabilities), and will further expand a local catalog of activities chart indicating which valued outcomes can be addressed within each activity (this chart was developed earlier by Preston Lewis and Jeanna Mullins). The project will further contract with each teacher to develop sample portfolio contents for two of her students, and will send out the written proceedings of the Advisory Committee meeting to each of the group's members. The *Office of Assessment and Accountability* will set up the arrangements for the Committee next meeting: **Tuesday, August, 11th,** and will notify each of the Committee members of those arrangements. Each of the six teachers will (time and schedule permitting) develop sample portfolio contents for two of her students, including the student who poses the most complex challenges.

At the Aug. 11th meeting, the Advisory Committee will:

- Focus on the recommendations and hopefully approval of the KDE Disability and Diversity Subcommittee concerning the Advisory Committee work of July 6-8 (the Disability and Diversity Subcommittee will meet on Aug. 6th);

- Consider the sample portfolios developed by the teachers and the difficulties and issues noted by the teachers;

- Consider the draft scoring standards and make revisions as necessary;

- Develop suggested formats for teacher, administrator, and parent training.

Alternate Portfolio Advisory Committee
August 11, 1992

Radisson Hotel, Lexington

8:30 Discussion of Teacher Portfolios - What Worked and What Didn't!

9:00 Review of Proposed Alternate Portfolio Teacher Guide

9:30 Discussion of Proposed Alternate Portfolio Guide and Teacher Examples of its Use

10:30 Break

10:45 Discussion Cont. - Consideration of Standards, Reconciling of Outcomes

12:00 Lunch

1:00 Training Issues:

- Development of Training Package and Sample Portfolios
- Regional Trainings (Expert Cohort Group with Representatives In Each Region - Identifying Regional 'Experts')
- Time Table for Portfolio Development (This Year) and Scoring (Next Fall)

Further Activities of the Alternate Portfolio Advisory Committee and Continuing Advisory Committee Role

MEMORANDUM

TO: Members of the KDE Alternate Portfolio Advisory Committee

FROM: Harold L. Kleinert

RE: Minutes of August 11th Meeting and Related Materials

DATE: August 12, 1992

Please find enclosed the written record of the August 11th meeting of the Alternate Assessment Advisory Committee. I believe that it was a very fruitful meeting and I thank each of you for your valuable contributions.

In addition, I have enclosed for your information a copy of our data base on the members of the committee. Please let me know (606-257-3045) if any information is incorrect or incomplete. I have also attached copies of two of the teacher portfolio descriptions discussed yesterday.

As we noted at the end of yesterday's meeting, we will convene again in late January to discuss the results of our state-wide training efforts, and to discuss future directions and modifications in the alternate portfolio process. We will set an exact date for that meeting after the training has been completed.

Again thank you for your participation. Do not hesitate to contact me if you have further questions or comments.

Alternate Portfolio Advisory Committee Minutes
August 11, 1992

Members Present: Carlene Gobert, Preston Lewis, Jeanna Mullins, Judy Tabor, Nancy LaCount, Rich Hill, Amy Sosman, Wendy Lakes, Sharon Davis, Sheri Moore, Ken Olsen, Pat Murphy, Sarah Kennedy, Pam Ellison, Connie McVicker-Smith, Jean Clayton, Jennifer Leatherby, Amy Reber, Jacqui Farmer, Harold Kleinert

Harold opened the meeting with a discussion of teacher comments on the alternate portfolio process they had used to develop their student portfolio descriptions. Teachers were in agreement that *starting* with each of the 27 valued outcomes, reconciling those outcomes to student behaviors, and then coming up with portfolio items to document each of those outcomes was a tremendously cumbersome process that often lead to not seeing the 'larger picture'. Rather, starting with an *activity-based* student schedule, and then reconciling *clusters* of outcomes to each activity and documenting the products or outcomes of those activities was perceived as a far better alternative.

Harold then presented the Draft Teachers Guide for group review. Members suggested a number of important revisions, including:

- Include a concise description of what the alternate portfolio is and who it is for in the introduction
- Include a glossary of terms at the end (e.g., natural supports, age-peers, etc.)
- In listing the set of required and optional portfolio item, clearly indicate those items that *must* be required from those items that *may* be included (i.e., separate lists)
- Always state standards in terms of student outcomes (e.g., skill is evidenced in multiple school and community settings). Also emphasize the creation of products and performances.
- Insure that there is a clear demarcation in suggested portfolio tasks/activities according to age
- Indicate clearly that portfolios should be developed and maintained for all students, with *scoring* at the 4th, 8th, and 12th grade levels. Portfolios should include the student's best pieces, which are defined as the student's typical work when he/she is doing well.
- Insure that performance of skills across persons is documented in the standards

- Ages or portfolio collection and scoring should include the *typical* ages at which students are in the 4th grade (9-10 years), 8th grade (13-14 years), 12th grade (anticipated last year)

- Insure that the coding for the personal management domain clearly reflects that this domain includes *community-based* activities under personal management

Sarah Kennedy and Pat Murphy then presented their individual student portfolio descriptions, which were developed using the proposed Teacher's Guide. Both teachers indicated that this process was much easier, clearer, and led not only to documentations of student outcomes but improved programming ideas as well. It appeared that the proposed standards were both applicable and usable with the individual portfolio descriptions. Harold noted that teacher portfolio descriptions will be included in the training package and that, if possible, actual student entries will be included as examples.

The afternoon was spent in developing a portfolio training plan. The first phase of training, to be held this fall, will include awareness and implementation knowledge so that teachers can begin to collect student portfolios. The second round of training, for next fall, will include specific training on scoring portfolios. This training can only occur after the collection of benchmark portfolios.

After some discussion of the inclusion of regular educators, administrators, and all Low Incidence (SPH, TMH, and MH) teachers in this training, the Advisory Committee developed the following plan.

- In late September, project staff will provide training to *regional* leaders from all eight state regions. Each regional team will include the regional assessment coordinator, one Low Incidence teacher knowledgeable about current best practices, and a faculty member in Low Incidence disabilities from a higher education institute (whenever possible). These regional leaders will assist project staff in providing training to the district teams from their region, and will be available for teacher questions and possible follow-up teacher workgroups on the portfolio process.

- In October and November, project staff and regional leaders will provide a one-day training for *district* level teams from each district in that region. District level teams will consist of: the local district assessment coordinator (team leader), a lead building principal (who has building level responsibility for students in the alternate system), a lead regular education teacher (who is currently involved in integrated programs), one additional central office staff member (e.g., special education coordinator), *and as many Low Incidence (TMH, SPH, MH and possibly self-contained EMH) categorical teachers as the district can send.*

- Should a local district *not* be able to send all of its teachers with lead responsibility for students in the alternate portfolio, it is the responsibility of the district to insure that those teachers receive adequate and timely training to begin student portfolios during the 1992-1993 school year. Districts will be held accountable for student performance in the alternate portfolio process.

- Project staff will conduct a teacher survey in January to determine the extent to which teachers in the field believe they have received sufficient information to start the process. This information will be used to target regional follow-up activities (teacher work groups, etc.).

The Alternate Assessment Advisory Committee decided to reconvene in late January (the exact date has not been set) to review the results of the regional training activities, teacher and administrator feed-back, and future needs for revisions and training in the alternate portfolio process.

Kentucky Systems Change Project
Alternate Portfolio Workshop for Regional Leaders

Monday, Sept. 28th, 1992
Springs Inn, Lexington

Agenda

8:30	Registration/Coffee
9:00	Overview of Training
9:10	Key Components of the Alternate Portfolio: Jigsaw Activity
10:30	Break
10:40	Questions and Answers
11:00	Student Schedules, Portfolio Entries, and Valued Outcomes
11:10	Identifying Portfolio Entries for Sample Students
12:00	Lunch
1:00	Identifying Portfolio Items for One of Your Own Students (That is, if you are a teacher!)
1:40	Discussion of Regional Training Formats and the Role of Regional Leaders
2:20	Alternate Portfolio System Time Table
2:50	Evaluations and Reimbursements Forms
3:00	Adjourn

KENTUCKY SYSTEMS CHANGE PROJECT

Kentucky Alternate Portfolio Assessment Project

1. ORGANIZATION

a. Were the sessions well organized?	4.43
b. Was discussion encouraged?	4.52
c. Were topics relevant to your job?	4.96
d. Was adequate time allowed for each session?	3.91

2. Presentation

a. Were the trainers well prepared?	4.83
b. Did the presentations stimulate your interest?	4.96
c. Were questions adequately answered?	4.43
d. Were the presentations clear and concise?	4.48
e. Were the meeting facilities adequate?	4.78

3. Overall Rating:

a. Did the sessions meet your professional needs?	4.83
b. Would you recommend these training sessions to other people?	4.91

4. Which presentations/activities were most valuable for you? Why?

Sample Student's portfolios
Examples of student's schedules, products, valued outcomes
All
Working on example student schedules
Doing actual portfolio activity
Information!
Group development of portfolio evidence & outcomes
Most Q-A activities
All- new information
Sample student
Doing a student
Actually getting into portfolio activities, specifically
The actual work on the schedule & coming up w/portfolio entries
All
manual, group activities, Q & A's
The whole program - sample students were helpful and educational

5. Which parts, if any, would you change?

It appears all of the possible variables have not been worked out at this time i.e., scoring for the most severely involved students. Provide a real portfolio as a sample.
Need explanations of valued outcomes
Make it mandatory to have teacher name, child age, date submitted on a small card to attach to each item in portfolio so all teachers feel like they are accountable.
Move questions to end. Shorten overview. Start examples before lunch.
Need more time.
Try not to read to participants
More time allotted
More hands on experience
Too fast; slower presentation - allow flexibility in Regional Training to meet needs of regions
Time allowed

BEST COPY AVAILABLE

6. General Comments:

I liked Judy's idea about having teachers bring their schedules to the training - it would save time in the afternoon when they "do" their own student. Is that possible?

Good session

You will never be able to please everyone - do what you believe to be best

Kept to time schedule - really appreciated that! I had a lot of apprehension about the portfolio - this helps some - There's still some unsureness, but until we actually do our own, that won't go away.

I realize time frames for project & KDE are set but districts are being inundated with vast amounts of information, one on top of the other, & also not communicating amongst their own staff. We need better integration with professional staff as well as students.

Very informative.

APPENDIX F

Project Newsletter (Spring 1992 Issue)

Volume 2, Number 2 Spring, 1992

Kentucky Systems Change Project

What's Inside

- **•Circles of Friends Invade Centerfield Elementary**
- **•Phelps School Becomes Civitan Educational Complex**
- **•Full Inclusion Program Piloted in Kenton County**
- **•Teacher Work Groups Provide Support**
- **•Inclusion Happens at Cardinal Valley Elementary School**
- **•Maps, Peers and Buddies: A University-School District Partnership**
- **•New High School Peer Tutoring Manual Available**
- **•Elementary Peer Tutoring**

Including Students with Moderate and Severe Disabilities at Warner Elementary School

"When Joe entered our room last year, he spoke only a few words and did not initiate conversations with other students. Now he talks in whole sentences, and asks other students to play. During writing time, when the other students are composing their stories, Joe tells me his story. I write it down for him and then he reads it back to me. His reading and math skills have improved considerably". This is how Ms. Gwen Ferguson, who teaches a first/second grade class at Warner Elementary School in Jessamine County, describes the progress that Joe has made in her class. What makes this story unusual is that Joe is a student with a moderate mental disability who is a full-time, regular member of her class.

However, Ms. Ferguson's response to the presence of a student with a moderate or severe disability in her class is *not* unusual for the regular education teachers at Warner Elementary. Ms. Connie Bruner, third grade teacher at Warner, has noted similar benefits for Dana, a student who has been labeled as having autism. "Dana feels that he is a regular part of this class. He has learned the class routines and expectations and most importantly he has learned to interact positively with the other students. He has learned a lot from them, including some of their bad habits!" Her other students have become more understanding of each other as a result of Dana'a presence in her class: "They see him as a person first. Even students who feel they have to be tough with everyone are considerate with Dana. In addition, the students have learned a number of signs from him". Ms. Bruner says that flexibility and an attitude of

See Warner on page 5

What is Support Networking?

What does a support team do?

Hopkins County Teachers have organized a team specifically designed to support teachers and students in inclusive settings. Pat Murphy, teacher at Madisonville-North Hopkins High School says that, in working with teachers who have included students with disabilities, providing the simplest of supports (e.g., materials, desks, an available ear) often opens the door to a wide range of opportunities.

What does a supportive classroom look like?

Mrs. Pat Fox, fourth grade teacher at Waddill Ave Elementary School uses an interactions, and cooperative approach to learning. Students in Mrs. Fox's class sit at tables and work in small groups. Small groups working together support each other in getting tasks accomplished while maximizing learning for all of the students. Involving students in activities that integrate learning into meaningful outcomes provides yet another element of support. These students developed plays, skits, and television shows revolving around a central theme.

What are the outcomes for the student with a disability?

The student included in Mrs. Fox's class has made tremendous progress. Her

See Supports on page 5

Circles of Friends Invade Centerfield Elementary!

Ms. Debbie Kilgore, SPH teacher at Centerfield Elementary in Oldham County, has started a unique program with all the classes in her school. In an effort to introduce her students "as children with needs, gifts and sensitivities like all other children" to the 500-plus students at the school, she has developed an adaptation of "Circle of Friends' that gives everyone in the school the chance to become involved on a personal level with her six students. Over the course of the first few months of the school year, all classes in the school are invited, in turn, to her room for a 30 minute intensive learning session. All students sit together, and she begins the lesson with a chart of concentric circles meant to illustrate the relationships that every person has in their life. At the very center of the circle are the persons closest to the student: the members of his/her family. The regular education students talk about the persons in their own circles of friends, and Ms. Kilgore points out the persons who fill the same roles in her students' circles. Out of this experience has grown her Helping Hands Program, which now totals 350 students at the school who have become involved with her class (nicknamed the "Hot Wheelers")! As a result, Ms. Kilgore is now going to specific classrooms to do more individualized "Circle of Friends" activities to facilitate more closely knit friendships. All students in the school are benefiting from this program, because all children are reminded of the importance of friendships in their own lives and of being a friend to others. However, the best evidence of the success of this program is from the students themselves. Look for letters and poems from Centerfield students throughout this newsletter.

"WHEN YOU DREAM ALONE IT IS ONLY A DREAM, BUT WHEN YOU DREAM TOGETHER IT IS THE BEGINNING OF REALITY."

Dom Helder Camera

Dear Holly,
I like you a lot. I wish you were in my class, I like working with you. Do you like me? Yes or No? My phone number is 222-0252. What is yours?
Your Friend,
Lindsey

Phelps School Becomes Civitan Educational Complex

During the past year, the Civitan Educational Complex in Hopkinsville has undergone significant change. For the past twenty-plus years, the Civitan School had been a self-contained school for students with moderate and severe disabilities in Christian County. Since 1987, enrollment has gone from a high of forty students to only twelve students at the end of the 1990-1991 school year. With students receiving earlier interventions, integration in regular classrooms, and community-based instruction, the needs of students and the role of the school began to change.

With the beginning of the present school year, Civitan School ceased to be a self-contained program, and it now houses three different programs serving the needs of both students and the community.

The first program is an integrated preschool program, serving both children with disabilities and nonhandicapped children. The program presently serves 36 children, including children from migrant families and children determined to be at risk as well as children with disabilities.

The second program is the Family Resource Center. This center serves two elementary schools in Christian County. The third program is the Parent Resource Center. This program serves all parents and families of students with disabilities in Christian County. An added dimension to this program is the lending library available to parents and teachers. Due to the generosity and support of the Civitan Club over the years in purchasing needed materials for students with disabilities, these items are now available to be loaned out on an as-needed basis.

The Civitan Center is now reaching out to meet the needs of students with disabilities and their families throughout the community. In addition, the Family Resource Center is meant to serve the needs of all students and their families. The Civitan Center has truly changed from a "separate school" to the Civitan Educational Complex!

Full Inclusion Program Piloted in Kenton County

by Mike Burdge

The Kenton County School System is implementing a pilot full inclusion program for four of its students with severe disabilities. Two students are in first grade and two are in the third grade. A unique aspect of this program is that these students now attend their neighborhood schools—Taylor Mill Elementary and Kenton Elementary. Planning began in the spring with site visits by the regular education staff to the students' previous cluster school, task force meetings, and training with Dr. Andrea McDonnell sponsored by Kentucky Systems Change Project.

Each classroom has a full-time teaching assistant and the part-time support of an itinerant special education teacher. The students with disabilities are included in all classroom activities and receive no"pull-out" services. The IEP's are all implemented within the context of regular education classes with adapted expectations, modified lessons, adaptive materials and equipment, and curricular adaptations when necessary.

The regular education classroom is not only proving to be an appropriate placement for students with severe disabilities but a much more stimulating environment as well. "Down time" has decreased and the opportunities for teaching functional, age-appropriate, embedded skills are numerous.

In addition to documented progress on targeted IEP goals, student progress has been noted especially in the areas of social skills, communication, and behavior. But, more importantly, these children are being viewed as friends, classmates, and fully participating members of their school community.

To: Melissa
From: Amy Chism

A special friendship that I have is to Melissa. She has a beautiful smile, and likes pizza, just like me. Melissa is different. She has cerebral palsy, but I don't see it as being different. I see it as being special. She can listen in a more thoughtful way than we can. Melissa is just down right nice.

Teacher Work Groups Provide Support

Two Systems Change teacher work groups started at the end of February. The Eastern Kentucky Group includes Bell County, Knott County, and Jenkins Independent school districts. In addition, members of the Upper Cumberland Special Education Cooperative have been invited to attend any meetings for which they may have an interest.

The Western Kentucky Teacher Work Group has resulted from an initiative of a group of Christian County teachers serving students with severe disabilities. These teachers decided that working with other teachers in their area would help them exchange ideas and problem solve difficult challenges related to serving their students. Christian County teachers have invited Hopkins County teachers serving similar students to join them for information sharing and problem solving sessions.

The formation of these two groups will serve their respective areas by bringing together the best knowledge and brightest expertise for developing innovative programming for students with challenging needs.

If teachers in your district would like to participate in any of these groups, Please contact Jacqui Farmer at theSystems Change Office 257-3560.

Elementary Peer Tutoring
LuAnn Duiguid, Christian County Teacher

In reading research and literature concerning peer tutoring, I have found that the consensus is greatly positive. My experience with peer tutoring is no different.

I teach a class of seven students in an elementary TMH program in Hopkinsville. I am constantly looking for ways to include my students with their nonhandicapped peers. Hopefully, the collaboration and interactions of both groups of students will provide quality experiences for both.

My classroom's peer tutors are from a fifth grade class. Four fifth graders join in our school computer lab for thirty minutes each day of the week. The tutors rotate weekly enabling almost everyone in the fifth grade classroom a chance to participate in the tutoring program. Even though I have seven students, only four of my students are presently in need of tutors. The other students work independently.

I am continually asking myself who benefits the most from peer tutoring. Is it my students because they receive academic assistance and must begin to communicate their needs to others? Or is it the typical students because they must look past my student's disability in order to get to know the person inside? In either case, both sets of students are being provided with an experience that will better prepare them in their lives ahead.

Inclusion Happens at Cardinal Valley Elementary School!

Lexington's Cardinal Valley Elementary School is the site of an exciting inclusive education program for two students with severe disabilities in the Fayette County Public Schools. Both students are members of ungraded (grades 2 - 3) primary classrooms, and spend at least 75% of their school day in activities with their regular education homeroom peers. SPH teacher Ms. Marianne Fox and ungraded primary teachers Ms. Melody Newton and Ms. Carol Perkins work closely together to adapt regular education activities to insure, that for both of these students, instruction and practice occur daily in targeted IEP objectives within the regular education classroom. These teachers are presently using the *The Assessment of Student Participation in General Education Classes* (McDonald and York, 1989) to measure the two students' progress in targeted IEP objectives in social and communication skills and in following typical classroom routines. Speech/language pathologist Ms. Millie Cohen and hearing impaired specialist Ms. Bambi Reed also provide direct services and support to these students in the context of the regular classroom. Other subject area teachers (computer class, PE, music, etc.) have developed creative adaptations for their programs. Ms. Brenda Holbrook, computer teacher, has noted the progress that both students have made in her computer class, and has seen direct gains in the students' IEP goal areas.

All of the teachers who have been working with these two students have seen tremendous benefits. Both students have greatly increased their social awareness, their initiations with other students, and their ability to follow verbal directions and participate in regular class routines. One of the two students, who also has a severe physical disability, has significantly increased his head control and now localizes to both students and teachers. In both participating regular classrooms, the teachers have noted increased sensitivities in their typical students to students with disabilities, and these teachers have noted how their typical students always consider the best ways for the students with disabilities to participate in the regular class activities.

Josh

There was a boy named
Josh
He wears Osh Gosh By
Gosh
He has black hair and
loves to share
Sure he wears glasses
He's in third grade for
classes
Josh loves kickball
He made it to third
base
He's in first place
Gee he is nice
What a prize
Samantha, Jenna,
Patrick, Michael

Maps, Peers and Buddies: A University-School District Partnership

The Jefferson County Schools in cooperation with the University of Louisville have come together in a unique partnership to support teachers of children with moderate to severe disabilities. Through a partnership grant, these agencies developed a teacher work group concept designed to provide teachers with information and support in serving children with challenging needs. Alexis Varney and Brenda Cooley from Jefferson County Schools and Dr. Sheri Moore from the University of Louisville report exciting changes and enhanced opportunities for teacher growth through this project.

The project contracted with Dianne Ferguson from the University of Oregon to work with the leaders of the work groups and to conduct a one day in-service for teachers. As a result, the teacher work groups will participate in research currently being conducted by Dianne Ferguson concerning the value of teacher support groups.

Using the McGill Action Planning System (MAPS-Forest and Pearpoint, 1989), each work group has developed a MAP of teacher concerns. Work groups meet to develop new strategies for integrating children with severe disabilities, problem solve challenging situations, and provide individual support.

BEST COPY AVAILABLE

Warner,

continued from page 1

openness are essential to the success of the program.

Mr. Bill Jones, a fifth grade teacher, includes Chad, a student with severe, multiple disabilities, in his home room, DARE and 4-H programs, Christmas program, all specials (art, music, PE, library) lunch and recess. "Chad has become much more responsive to others as a result of his inclusion in our class; Chad's mother has seen this as a very important opportunity for Chad," Mr. Jones notes. His other students have gone out of their way to talk with and to include Chad. Those students in his class who have been the most considerate are rewarded by getting to accompany Chad in his community-based instruction, so even CBI becomes an important opportunity for integration!

Teaming and collaboration are important aspects of integrated education at Warner. Ms. Bettye Hartlage, TMH teacher for primary-age students, team teaches whole language lessons with Ms. Margaret Curtsinger in Ms. Curtsinger's regular kindergarten class. Ms. Hartlage and Ms. Curtsinger take turns in introducing large group activities. When the students break into small groups, Ms. Hartlage takes the group that has Lindsay, a student with a communication disorder, who entered Ms. Hartlage's program this year. In this way, Ms. Hartlage can model for the 'regular' kindergarteners appropriate ways to interact with and to assist Lindsay. As her role expands, Ms. Hartlage will be providing assistance to other kindergarten students, many of them not 'labeled', who nevertheless require individualized instruction or adaptations to succeed.

All staff are part of this total school effort. Ms. Susan Hall, Warner speech/language pathologist, notes that all related service objectives, such as communication goals, are directly embedded into school activities throughout the day, including regular class instruction. How does a school attain this level of teamwork? It has been a systematic, gradual process over the past two years, according to Ms. Hall. Perhaps the most important ingredients in the process were summed up by Ms. Connie McVicker-Smith, TMH teacher assigned to the older elementary-age students at the school. "First you have to integrate *yourself* in all aspects of the school", she says. "I assist Bill Jones with our academic team. None of my students are involved in this competition, but I become viewed as a regular part of the faculty, and the students on the academic team become a wonderful source for friends for my students. We have an important philosophy at this school: all teachers (including all staff) are responsible for all kids".

Supports,

continued from page 1

communication and social skills have improved. She has learned to climb steps and hurries to keep up with friends. She has started to read. By the end of October, she had met the objectives on her IEP and a new one had to be developed. Best of all, she *belongs* with the class. Other students care for her, look out for her, and support her in achieving common goals.

How does everybody feel about this inclusion stuff?

Mr. Sam Aldridge, Principal at Waddill Elementary School, expressed cautious optimism. He wants to insure that legal obligations regarding the student are being met, as well as learning outcomes for the other students in the class. Special Education teacher Robin Vance expressed excitement at the student's progress but concern about transition to middle school and in being able to provide the right kinds of support to the student and to the regular teacher. Special Education Director Sheila Mills also related both excitement about progress and concern about providing the right kinds of support for students on a continuing basis. According to school personnel, the student's mother also has expressed excitement about her daughter's progress and concern about what the future holds.

*Inclusion means support and support means the following:**

- Helping students and families realize their own vision of a good life.
- Listening to and acting on the support needs identified by students, families, and other team members.
- Re-allocating resources so that students can be included in regular school life, and teams can work together.
- Remembering that the students are the "stars" and that the educational team members are the supporting actors.
- Acknowledging the efforts of the team members.
- Designing curricular and instructional methods that assist the student to be an active learner.
- Providing constructive feedback to fellow team members that results in more effective team interactions and ultimately improve student learning.
- Providing the right kind of information.

*York, Giangreco, Vandercook, and MacDonald, 1992

New High School Peer Tutoring Manual Available

The *High School Peer Tutoring Manual*, published by the Kentucky Department of Education for use in the High School Peer Tutoring Course, has been recently revised by staff of the Kentucky Systems Change Project. The new manual has been formatted in easy-to-read MacIntosh print, includes a total of nine modules, and many new up-dated readings. The expanded format gives school systems the option of offering the course on a one semester or a full-year basis. The Peer Tutoring Course is designed to enable high school students to learn about the challenges and needs of persons with moderate and severe disabilities, while tutoring these students one period a day at their school. This course has been offered on an experimental basis by at least 30 Kentucky school systems since 1987. If you are interested in learning more about High School Peer Tutoring, you can receive your own copy of this manual at no cost by contacting Mr. Preston Lewis or Ms. Jeanna Mullins, Office of Learning Program Development at 502-564-4970. If you want to offer this course at your school, you must file an application for an Enrichment Course with the Kentucky Department of Education by May 30, 1992 for the 1992-1993 school year. See your building principal about this.

Dear Mr. Hamman,

Some kids have freinds that ride the handycapt bus. So one of my classmates and I have thought that there should be a bus that handycapt people and people without a handycapt ride the bus together.

Sign,
Mike Gray and
Mike Smallwood

Students at Wilmore
Elementary School,
Wilmore, KY.

Kentucky Systems Change Project for Students with Severe handicaps
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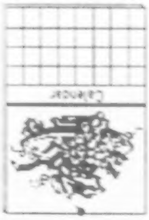
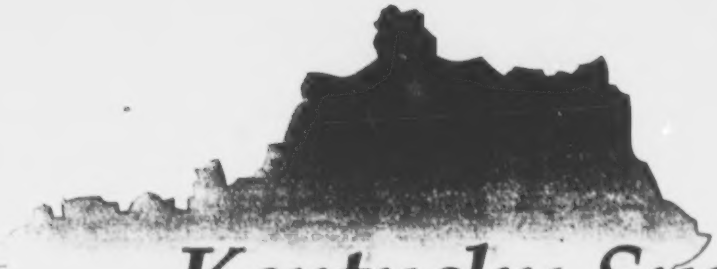


Mark Your Calendar

Kentucky CEC Conference
March 26 - 28
Drawbridge Inn
Ft. Mitchell, KY

APPENDIX G

Services for Students with Special Health Care Needs Manual



Kentucky Systems Change Project

Services for Students with Special Health Care Needs

Guidelines for Local School Districts

Pamela D. Smith, Ed.D.

Jennifer L. Leatherby, M.S.

A project conducted by the Interdisciplinary Human Development Institute—University Affiliated Program, University of Kentucky for the Kentucky Department of Education, Office of Education for Exceptional Children. Funded by the U.S. Department of Education, Office of Special Education Programs, grant number G0087C3061-90 and 91.

SERVICES FOR STUDENTS WITH SPECIAL HEALTH CARE NEEDS

Guidelines for Local School Districts

September. 1992

prepared for the

Division of Special Learning Needs
and the
Division of Exceptional Children Services

Kentucky Department of Education

by

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FOREWORD

There was a time when the ability to care for one's self was a prerequisite to admission into many public schools. No child who was not toilet trained would be permitted to attend! With changes in attitudes and laws have come changes in student populations. Consequently, now we are fairly accustomed to teaching students who have not yet learned to toilet themselves and those students who have not yet learned to feed themselves.

The newest change in today's school is the inclusion of students whose care needs extend beyond those that might be considered basic, such as feeding and toileting or changing. Many of these students require the provision of health care services that extend way beyond that which has been traditionally identified as school health services. In today's public schools we are educating students who require specialized health care services such as gastrointestinal tube feeding or catheterization for elimination of urine or continuous oxygen through a ventilator to assist their breathing. These student who previously attended school in either hospitals or at home, are now being educated in school based classrooms. Consequently, numerous questions and issues arise regarding their education and their needs for related or medical services. Students with special health care needs have proved to be a challenge to personnel in every level of education systems.

Administrators, transportation providers, teachers, nurses, therapists and other personnel in the schools have come together in planning to meet the needs of these students. These personnel have often felt like pioneers, newly meeting the challenge of the students without the benefit of prior experience or resources to assist them in their efforts.

While the entry of each new student with special health care need will continue to present individual challenges, a body of both published and unpublished literature has emerged that can serve to guide administrators and program planners in providing for safe educational environments for these students, their peers and school personnel. This literature is based on case law, research and practical experience with educational and health care service delivery to children with special health care needs who have become students in special and regular educational settings. While no one document could possibly provide all the information needed, the authors of "Services for Children with Special Health Care

Needs: Guidelines for Local School Districts" have drawn from the extant literature and have very effectively synthesized, complied, referenced and/or augmented it. Its content should enable the authors to meet their goal of providing "...districts and parents with a basic understanding of what needs to occur to appropriately service children with special health care needs" (p.5).

Donna H. Lehr, Ph.D
Associate Professor
Boston University
Chair, TASH Critical Issues Subcommittee on
Individuals with Special Health Needs

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STUDENTS WITH SPECIAL HEALTH CARE NEEDS

Historically, many children with special health care needs did not survive to school age or were served at home or in hospital settings. With advances in health care and medical technology, more of these children are surviving, living at home, and being served by local school districts in Kentucky. These school districts are faced with financial, educational, legal, and health related issues that they have never faced before.

In the summer of 1990, the Kentucky Systems Change Project for Students with Severe Handicaps organized a subcommittee of its Advisory Board to develop state guidelines for providing health related services to children with special health care needs. This endeavor was requested by the Kentucky Department of Education, Office of Education for Exceptional Children to provide needed direction for local school districts. This document includes information that addresses definitions related to students with special health care needs, related Kentucky regulations, the results of a statewide survey of teachers regarding service provision, belief statements regarding quality service provision, placement and development of individualized program plans, provision of related services, training of unlicensed personnel to provide health care services, emergency procedures, and transportation issues. Many of these issues will require further exploration and development. However, we believe that the information in this document will provide local school districts and parents a basic understanding of what needs to occur in order to appropriately serve children with special health care needs. The appendices include additional information about specific health care procedures, other health concerns, developing IEPs, sample forms for training and documentation, related readings, and other recommended resources.

Definitions

All children have health care needs related to school attendance. These needs may include something as simple as having a temperature taken or applying a bandage to a skinned knee. Other students may have conditions and/or illnesses that require special health care considerations such as the student who must have daily insulin shots due to diabetes. Additionally, some students may have special health care needs that require more intensive health care services or a broader range of services.

Under certain circumstances, students with specific health impairments may be eligible for special education services based on their health care needs. P.L. 94-142 specifies that a student is eligible for special education and related services or support services due to a health impairment if the following conditions exist:

1. The child has limited strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, sickle cell anemia, hemophilia, epilepsy, rheumatic fever, nephritis, asthma, lead poisoning, leukemia, or diabetes; and
2. The condition(s) of the child adversely affects the child's educational performance.

The key to eligibility for children with health impairments is the extent to which the health impairment impacts the child's ability to perform in school. For example, many students with diabetes do not receive special education services due to the fact that the condition does not adversely affect their educational performance. Likewise, students with epilepsy do not automatically qualify for special education because of this condition. While the student with epilepsy may require health services in the form of seizure monitoring, special education is not required unless epilepsy negatively effects the student's educational performance.

There is yet another category of students who do not fit under the categorical label of "Other Health Impaired". These students require intensive health care services and are generally placed in special education based on their primary handicapping condition: multiple handicaps, severe handicaps, or deaf-blindness.

For the purposes of this document, children with special health care needs are described as those children who require individualized health related interventions to enable participation in the educational process. Included within this population are children who:

1. have unstable medical conditions or who may require emergency medical procedures,
2. require special health care procedures during the school day, or
3. use a particular medical device that compensates for the loss of a body function and who require substantial, and complex or frequent health care to avert death or further disability (adapted from Iowa Department of Education, 1988).

This document will primarily focus on the provision of services for students whose primary handicapping condition is a physical disability, multiple disabilities, or severe and profound disabilities including deaf-blindness, and require the special health care interventions or procedures that are described in Appendix A. These procedures include administering medications, catheterization, gastrostomy tube feeding, glucose monitoring, ileostomy and colostomy care, nasogastric tube feeding, respirator dependent, seizure monitoring, and tracheostomy care and suctioning. In addition, many students who require these procedures may have additional health related concerns such as prevention of bone and joint deformities, bowel care, cast care, congenital heart disease, feeding/eating disorders, nutritional concerns, othotics care (braces and splints), prosthetics care, shunt monitoring, and skin care (see Appendix B for descriptions and related information).

Related Kentucky Regulations

Currently, there are no Kentucky regulations for provision of educational services for students with special health care needs. However, there is a wealth of general health related information in the *School Health Services Manual* (Department of Education, 1990) and all teachers in Kentucky need to have access to this document and training related to its content.

When determining if unlicensed school staff can administer health care procedures, two questions must be answered: a) Does the procedure have to be administered by a physician?, and b) Do the current state nursing laws state that the procedure(s) can only be administered by a registered or practical licensed nurse? If the procedure can only be administered by a physician, then it is a medical service (not a related service and the school system is not obligated to provide it) and unlicensed school personnel **cannot** perform the service. **If the procedure can be administered by a registered or licensed practical nurse, it is a health related service**; and thus, a review of a state's current "Nurse Practice Act" provides us information on whether or not the procedure can only be administered by a nurse or whether a nurse may teach, supervise and delegate the performance of the procedure to others. A review of Kentucky Revised Statute Chapter 314 (*Kentucky Nursing Laws* ,1992) defines nursing practice, in summary, as the performance of acts requiring specialized knowledge, judgement, and skill; and **permits nurses to teach, supervise and delegate the performance of selected acts to unlicensed personnel who possess adequate training and skill to perform the act in a safe, effective manner**. KRS 314.011 (2) states: "Delegation means directing a competent person to perform a selected nursing activity or task in a selected situation under the nurse's supervision and pursuant to administrative regulations promulgated by the Board of Nursing ....". The term "supervision" is defined by the Kentucky Board of Nursing to mean the provision of guidance by a qualified nurse for the accomplishment of a task with periodic observation and evaluation of the performance of the task including validation that the task has been performed in a safe, effective manner. Thus, unlicensed school personnel may perform selected nursing acts under the delegation and supervision of a nurse and/or physician. The nurse or physician is **not** required to be on site to provide direct supervision when unlicensed personnel have been trained by a nurse and/or physician to perform the act. The only health care procedures discussed in Appendix A that cannot be performed by a teacher (even with training) include administering injections, nasogastric tube feedings and medications via this route, and sterile urinary catheterization. In addition, a student who is respirator/ventilator dependent requires complex, specialized health care support performed by a licensed health care provider.

Results of Statewide Survey

Given the above information, a statewide survey of teachers in SPH, TMH, MH, and OHI units (classrooms) was conducted to determine the current trends in the delivery of health related services for students with special health care needs in Kentucky (Smith, Leatherby, & Wasson, 1991). The survey was designed to answer four main questions: 1) Who is performing health care procedures in the classroom?, 2) What type of training did this individual receive?, 3) Who provided the training?, and 4) What district policies or guidelines determined the process of the delivery of these procedures? This survey was an adaptation of a similar one conducted in Kansas (Mulligan-Ault, Guess, Struth, & Thompson, 1988).

Of the 503 surveys mailed to all teachers in SPH, TMH, MH, and OHI classrooms in Kentucky, 272 were returned for a return rate of 54%. Of the 272 that were returned, sixty-five (23.9%) were not applicable because health care procedures were not required for any of the students in the classroom. Nineteen (6.9%) of the surveys contained omissions regarding their training in performing special health care procedures. Follow-up phone calls were conducted in September, 1991 to obtain the missing information and those 19 surveys were added to the sample. Thus, a total of 207 surveys were the sample for the study.

The results of the survey indicated that:

1. Over half (53.6%) of the teachers reported that no nurse was available to assist them, while 45.8% indicated that a nurse was available.

2. When nurses were available, 23.1% of the teachers reported that a nurse only came upon a specific request, 31.5% reported that a nurse was in their classroom only two to four times a year, and just 17.8% reported that a nurse was in their classroom at least once a day.

3. When teachers who have a school or itinerate nurse available where asked about the role of the nurse, they indicated that the two primary roles of the nurses were most frequently consultant (32.8%) and less frequently the direct service provider (12%).

4. Of the teachers responding, 63.2% reported no correspondence with their students' family physicians, while 31.8% indicated they did correspond with their students' physicians.

5. When teachers were asked if they had **written instructions** for the procedures they performed, 82 or 39.6% of the teachers reported "NO", 57 or 27.5% reported "YES", and 58 or 28% provided no response. One teacher commented that the instructions were received "over the phone".

6. Numerous answers were provided to the question of who determines who should perform the procedure. These included ARC determines

(34.7%), parent recommends/determines (31.4%), teacher decides (20.7%), and nurse recommends (10.6%).

7. The **27 health care procedures** that were listed in the survey and performed in the classrooms of the teachers surveyed ranked in the following order of frequency: 1) handling and positioning, and medication administration (both performed in 96.6% of the classrooms); 2) wheelchair care and monitoring (performed in 61.8% of the classrooms); 3) bowel care (performed in 55% of the classrooms); 4) braces care/monitoring fit (performed in 48.3% of the classrooms); 5) cardiopulmonary resucitation (CPR) (trained to perform in 47.3% of the classrooms); 6) skin care and monitoring (performed in 41.5% of the classrooms); 7) teeth and gum care (performed in 40.5% of the classrooms); 8) diet monitoring (performed in 33.3% of the classrooms); 9) gastrostomy tube feeding (performed in 28.9% of the classrooms); 10) splint care/monitoring (performed in 20.7% of the classrooms); 11) cast care (performed in 16.9% of the classrooms); 12) shunt monitoring (performed in 14.9% of the classrooms; 13) catheterization and postural drainage (both performed in 14% of the classrooms); 14) percussion (performed in 9.6% of the classrooms); 15) monitoring blood/urine glucose levels, bulb syringe suctioning of tracheostomy, machine suctioning of tracheostomy, and changing trach tubes (all four procedures performed in 6.2% of the classrooms); 16) changing trach ties (performed in 5.7% of the classrooms); 17) colostomy or ileostomy care (performed in 3.8% of the classrooms); 18) nasogastric tube feeding (performed in 2.8% of the classrooms); 19) administering enemas (performed in 2.4% of the classrooms); 20) oxygen supplement (performed in 1.4% of the classrooms); 21) delee suctioning (performed in 0.96% of the classrooms); and 22) prosthesis care (performed in 0.4% of the classrooms).

8. Of the 27 health related procedures or concerns listed on the survey (see #7 above), **92.5% or 26 of the procedures were performed most often by teachers**. Only two procedures were performed more often by other persons: Catheterization performed most often by the teacher assistant (41.3%) and delee suctioning was performed most frequently by a nurse (100%). In addition, paraprofessionals or teacher assistants were performing 22 of the 27 procedures (81.4%) and nurses were performing 21 of the 27 (77.7%).

9. When teachers were asked to indicate **how they were trained** to perform the procedure, direct training via **consultation by a nurse or other licensed health care provider** was most often used as a means of training (55.5%) when training braces care, cast care, catheterization (informal training provided by family members with equal frequency, see below), colostomy and ileostomy care (informal training provided by family members was indicated with equal frequency, see below), handling and positioning, oxygen supplementation, percussion, postural drainage, prosthesis care, skin care, splint care, teeth and gum

care, machine suctioning, changing trach tubes, and wheelchair care. **Informal training by family members** was the most common training method used (44.4%) when teachers received training in catheterization (training provided via consultation from a nurse or other licensed health care provider was indicated with equal frequency, see above), colostomy and ileostomy care (training provided via consultation from a nurse or other licensed health care provider was indicated with equal frequency, see above), diet monitoring, administering medications, monitoring blood/urine glucose levels, skin care, bulb syringe suctioning, changing trach ties, gastrostomy tube feeding, and nasogastrostomy tube feeding (training being provided via formal inservice training was indicated with equal frequency, see next statement). **Formal inservice training** was utilized most often (7.4%) with the two procedures of CPR and nasogastric tube feeding (informal training provided by family members was indicated with equal frequency, see above). **Preservice training** (college or university) was listed most often (3.7%) only for bowel care.

10. When the teachers were asked who conducted the training, **family members were the most frequent providers of training**. Family members provided training most often in 14 of the 27 procedures listed on the survey (51.8%) including braces care, catheterization, colostomy/ileostomy care, diet monitoring, enema administering, administering medications, monitoring blood/urine glucose levels (training provided by nurse and physician with equal frequency, see below), shunt care, skin care, teeth and gum care, bulb syringe suctioning, changing trach ties, gastrostomy tube feeding, and nasogastric tube feeding. **Nurses provided training second most often** (22.2%) primarily in procedures of CPR, monitoring blood/urine glucose levels (training provided by family members with equal frequency, see above), oxygen supplementation, postural drainage, machine suctioning, and changing trach tubes. Physical therapists also provided training in 10 of the 27 procedures listed. They provided training most often in the procedures of cast care (40%), percussion (45.4%), prosthesis care (100%), splint care (60%), and wheelchair care (47.3%). Occupational therapists provided training in 7 of the 27 procedures including braces care, cast care, handling and positioning, percussion, skin care, splint care, and wheelchair care. University professors and instructors provided training in 5 of the 27 procedures, and provided training most often in bowel care and establishing bowel habits. Doctors provided training to some teachers related to 14 of the 27 procedures, but did not provide training most frequently in any of the 27 procedures included in the survey.

The results of the statewide survey indicated that teachers are providing the majority of the health related services for students who require them during the school day. When teachers or other unlicensed school staff are the designated health care service provider/implementer, they have not been trained by a nurse, physician, or other licensed health care provider. In most cases, unlicensed school personnel who are performing the procedure or providing the service on a regular basis do not even have written instructions to follow. In addition, few districts have written policies or procedures for the delivery of special health care services and related training specifications. It is recommended that school districts follow the training model described in the following section to ensure that unlicensed school personnel are adequately trained to reduce the risk of liability and provide a safe and healthy learning environment for students.

Belief Statements

To develop appropriate educational programs for children with special health care needs, a few basic guidelines should be understood by all persons involved in the process. The belief statements that follow form the basis for the recommendations and contents of this document and are provided as basic guidelines for local district personnel and parents:

1. Children with special health care needs can participate successfully in learning experiences.
2. All children with special health care needs do not require special education.
3. All children who qualify for special education services are placed in the least restrictive environment, so they can actively participate in activities with their nondisabled peers to the greatest extent possible. All educational programs are provided in learning environments that are safe and clean, minimizing health risks for all involved.
4. Educational placements are not based solely on the basis of the need for health care services, nor as a result of a category of handicapping condition or "label", or the configuration of the existing service delivery system. If placement outside the regular classroom is needed, provisions are made for frequent interactions with the child's nondisabled peers.
5. Educational placements for students who qualify for special education services are not made on the basis of availability or location of related services or support services, but on the most appropriate setting in the least restrictive environment for each individual student. Related services are clearly defined in terms of the type, nature and extent to which they will be provided and who will provide the services.
6. Each child with special health care needs is handled through the regular entrance and/or ARC processes, taking into account individual health care needs at each stage of the process.
7. Every child who has a special health care need requiring care, intervention, or supervision should have a written plan of care established as outlined in the IEP.

8. Families are full partners in the decision making process because they are often the best informed about their child's health history and current status.

9. Educational program decisions are made by an interdisciplinary team that includes: personnel knowledgeable about the student, the evaluation data, and placement options; the child's parents; and the school nurse or other licensed health care professional with input from the child's physician. Team decisions take into account the child's health care needs and educational needs, appropriateness of the educational setting, risks to the child, and training needs of unlicensed school personnel.

10 Health care professionals currently providing services to children with special health care needs are recognized as valuable and necessary team members and participate in the decision-making process in the identification and interpretation of health information for the entire staff and should provide child specific training to nonlicensed personnel.

11. The provision of proper training and information about the provision of health care services and legal issues in regard to this population of students can promote attitudes that these children can be appropriately served in the schools.

12. School nurses or other licensed health care professionals are valuable members of the service delivery team who maintain responsibility direct or indirect service provision, and for training, delegating and supervising the performance of health care related procedures by unlicensed school personnel. In addition, they function as the designated qualified health care professional who is accountable for a) making appropriate delegatory decisions, b) assuring that appropriate training has been provided for each health care service provider/implementer, c) verifying the initial and on going competence of the service provider/implementer to insure safe, effective care, d) conducting periodic assessments of students to assure that proper health care services are being provided and e) providing appropriate supervision of unlicensed personnel who perform health related procedures.

13. Financial responsibility and reimbursement considerations are issues when serving children with special health care needs. Educational agencies are not required to assume financial responsibility for noneducationally related medical services and supplies.

These belief statements were adapted from those contained in *Recommendations: Services for Children with Special Health Care Needs* (Iowa Department of Education, 1988) and *Report of the Council for Exceptional Children's Ad Hoc Committee on Medically Fragile Students* (1988). These statements formed the basis for developing the content in this document. In addition, the subcommittee reviewed several other key documents including *Guidelines for the Delineation for Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting* (The Joint Task Force for the Management of Children with Special Health Needs, 1990), *Issues in the Education of Students with Complex Health Care Needs* (Lehr & Noonan, 1989), and *Health Care for Students with Disabilities* (Graff, Ault, Guess, Taylor, & Thompson, 1990). Much of the information in this document is based on these previous works and the experience of professionals currently serving these children in school districts in Kentucky.

Placement and IEP Development

As previously stated, not all children with special health care needs require special education services. However, whether the child qualifies for special education services or not, schools must have information about the child's health care needs in advance of the child's entrance to school so that all required planning, provisions, and staff training can occur.

Ideally, the parent(s) or guardian of a child with a special health care need will notify appropriate school officials that their child needs special health care services. The school official should, in turn, contact the school nurse or designated licensed health care provider responsible for planning and training. Based on an educational assessment, the school system will determine if the child qualifies for special education services. Regardless of whether the student qualifies for special education services, a meeting is convened to review the health needs of the child. In cases where the child **does** qualify for special education services, the review may occur at the Admission and Release Committee (ARC) meeting. Persons present at this meeting include the chairperson (building principal), referring teacher or teachers, parents, the student (when appropriate), other persons providing input into the individual education program as requested by any member of the ARC, and personnel responsible for providing and interpreting evaluation information (707 KAR 1; 051). When a student has special health care needs a school nurse or other licensed health care provider should be present during the meeting. In addition, other persons that may be requested to attend the meeting may include other teachers involved with the student, school health coordinator, director of special pupil services, school guidance counselor, and other appropriate team members as needed (speech-language pathologist, physical therapist, occupational therapist, etc.). One of the primary purposes of this meeting is to determine the extent to which the student will require special health care services.

The following questions are answered during the meeting:

1. What are the types and nature of the services to be provided?
2. What is the extent and frequency of services to be provided?
3. Which agency has responsibility for specified health care services?

4. What, if any, interagency agreements are required if an agency other than the school district is providing the health care services?

5. Where and under what conditions are the services to be provided?

6. Who will be the designated health care service provider/implementer (e.g., school nurse, other licensed health care provider, unlicensed school personnel)? If the designated health care service provider/implementer will be an unlicensed school staff member, how will they be trained and who will supervise and monitor the service delivery (see section entitled Training Unlicensed School Personnel to Perform Special Health Care Procedures)?

7. What transportation services are needed and will special health care services need to be provided during transport?

8. How will emergency situations be handled?

9. How often will the service delivery plan be reviewed?

10. What are the criteria for terminating services?

11. Who will coordinate the delivery of health related services or support services to assure that appropriate services are provided for the student (e.g., school nurse or other licensed health care provider)?

12. How will the student participate in the health care procedure? Can the student learn to perform all or parts of the procedure with training and monitoring? Does the health related procedure provide a context for instruction of basic skills (e.g. communication) or partial participation?

All discussions and recommendations regarding the special health care needs of the student are clearly documented. If the child has been placed in special education, much of the information obtained from the questions above is included in the Conference Summary Report, as well as in the student's Individual Education Program (IEP). For example, all health care interventions that will be conducted at school are documented in the IEP. Who will perform the service(s), where, and under what circumstances are also clearly stated. Appendix C contains examples of how health care services are documented on the IEP and how to develop IEP objectives that use these routines as valuable instructional opportunities instead of just care taking tasks.

All efforts focus on providing the student an appropriate educational program in the least restrictive environment, ideally in the child's neighborhood school. Health care needs alone or "labels" do not determine educational placement. The ARC must determine the types and levels of supports that would be necessary to provide an appropriate education in the least restrictive environment.

A critical component of planning for educational services for children with special health care needs is the information collected from sources and agencies outside the school system. Standard school medical information forms will not adequately elaborate the detailed information necessary for program design and implementation. It is critical to obtain information from the child's physician that pertains to care at school. In all instances, the parents must sign a release of information form to obtain any and all information from sources and agencies outside the school system.

Most physician's offices are very cooperative about sharing information about the child's needs and subsequent problems that might occur. In many cases, efforts may be required to establish a working relationship with the physician for the benefit of the child. Appendix D contains a sample cover letter and forms that may be used to obtain information from physicians. If a response to your information request is not received in a timely manner, follow the request with a telephone call. If necessary, forms can be hand delivered by the parents or guardian, or school personnel.

How much information is gathered and how to use the information gathered is not always easily ascertained. Sometimes, educators expect more information than is available or needed to make decisions in the realm of educational programming. Often, the best source of information is the parent or guardian and information gathered from the physician is used to confirm the information from the parents.

Information about etiology (cause) and other areas, while interesting, are not necessarily critical to our ability to provide services to the student. It is important to respect the confidentiality of medical and health related reports, while at the same time, gathering the information necessary for good educational planning and decision making. Any request for information made to an agency outside the school system is accompanied by a release of information form signed by the parents. Requests for medical and health related information are worded very specifically, rather than generally, stating questions so that they can be easily answered by the physician with the simplest answers possible. If we do not ask specific questions or provide parameters in our information requests, we may get information that is not pertinent and still not have the information we need.

A useful method of verifying and gathering additional information related to a specific health care procedure that a particular student requires is to have the parent meet with the school nurse or other licensed health care provider to list and explain the steps in the procedure in great detail. The school nurse or licensed health care provider verifies the accuracy of the detailed description of the procedure using the Program Plan and Training Form in Appendix E. The information contained in Appendix A on specific procedures may also be used to obtain additional pertinent information when talking with parents and completing the Program Planning and Training Form. If this information is clearly recorded and verified by the school nurse or other licensed health care provider, it can then be sent to the physician for verification and authorization. It is not recommended to ask the physician to complete detailed description (steps) in the procedure. The parents input is vital regarding individual adjustments in the procedure for their child and physicians may not be trained or experienced in the particular procedure. In addition, using this approach may greatly reduce the response time from the physician to obtain the authorization signature (See page one of the Program Planning and Training Form in Appendix E for physician's signature.). Once the physician has signed this completed form, it becomes the program plan for the student and is used as the training form by the school nurse or other licensed health care provider to train unlicensed school personnel who may be designated to be the health service provider/implementer and perform the health care procedure (see section entitled "Training Unlicensed School Personnel to Perform Special Health Care Procedures").

Provision of Related Services

Students who receive special education programs may require related services such as audiology, counseling services, identification, medical services (for diagnostic and evaluative purposes only), occupational therapy, parent counseling and training, physical therapy, psychological services, recreation, special health care services, social work services, speech pathology, and transportation. Students with special health care needs often require health care interventions during school hours in order to benefit from special education. Public Law 94-142 clearly states that medical services which have to be performed by physicians are not considered related services or support services unless they are solely for purposes of diagnosing or evaluating a student.

A precedent has been set for providing health related procedures during the school day. In Irving Independent School District vs. Tatro (1984), the United States Supreme Court ruled that clean intermittent catheterization was considered a related school health service that enabled a 3 1/2 year old child with spina bifida to benefit from special education. In the Department of Education, State of Hawaii vs. Dorr (1982) a similar decision was made. It was determined that reinsertion of a tracheostomy tube could be performed by a school nurse or other trained school personnel and was therefore considered a related school health service. It is worth noting that the procedure was considered a school health service as opposed to a medical service, which must be provided by a licensed physician. School health services may be provided by a school nurse or other trained school personnel.

In matters where the issue is one in which the school is asked to administer a particular procedure or provide a health care service, the courts appear to favor the plaintiff (child and family). However, when the issue is in regard to who pays for specific services, the courts are more likely to favor the school system. Thus, parents were responsible for supplying the equipment and supplies for health care procedures conducted at school. Two cases typify these circumstances. In Detsel by Detsel v. Board of Education of Auburn (1985) and Bevin H. by Michael H. vs. Wright (1986) parents asked the school system to pay for nursing services for their children upon entrance to public school. In both cases, procedures such as suctioning and administration of medications through a gastrostomy tube had previously been conducted by nursing services and paid for by outside funding sources. It was determined in both situations that the school system was not responsible for paying for nursing services to perform these procedures. In summary, according to the outcomes of these cases, school systems are obligated to provide needed health care services (related or support services) or work with the family and other state agencies to obtain these services. However, parents supply needed equipment and other supplies, except for protective gloves, which the school system provides to school staff. However, these decisions were made in local judicial systems on a case by case basis and do not have the same precedence setting impact of the Tatro case.

In summary, the health related interventions commonly required of students with special health care needs can be considered related services or support services if they **do not** have to be performed by a physician. Referring to such procedures as school health services strengthens the position that the procedure is a related service that enables a student to benefit from special education.

Consideration is also given to that population of students with special health care needs who require special health care considerations or interventions during school but do not otherwise qualify for special education. Public Law 94-142 clearly states that students must qualify for special education before they are eligible to receive related services. A student with cystic fibrosis who requires daily percussion and who is placed full time in a regular class would fall into this category. While this student cannot receive the related service under P.L. 94-142, the student may receive the service under another federal law, Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112). This law does not require that students be placed in Special Education to receive related services.

Training Unlicensed School Personnel to Perform Special Health Care Procedures

Appropriate training of school personnel is a critical component of service provision to children with special health care needs. Training focuses on the attainment of specific competencies by persons involved in working with the student. **Three levels of competencies** require consideration: a) **general information**, b) **informational competencies**, and c) **performance competencies** (Lyon & Lyon, 1980). It is recommended that information and resources in this document be incorporated into these three levels of training activities. It is recommended that all school personnel involved with a student's program and daily activities will require training in general information related to the student's particular health care needs. In addition, a number of these persons will require more intensive training focused on informational competencies related to the student's health care needs and interventions. When unlicensed school personnel are designated by the ARC as the health care service provider/implementer, the most intensive level of training is required so that personnel can attain the performance competencies required to provide the health care service.

General information (awareness) is provided to all persons involved with the student such as all the student's teachers and other key school personnel. This may include a description of the special health care need(s), the purpose of the procedure or service, who is responsible for administering the procedure/providing the service, where and when the procedure or service will be provided, and other general information deemed pertinent, such as who to contact within the school setting in case of problems or emergencies.

Other examples of general information that should be provided to all school personnel include district policies and procedures related to documenting absences and illnesses, basic first aid, administering medications, and procedures to contact parent(s) when students become ill during school hours. All districts and schools have these basic procedures and all staff should be provided this information.

Informational competencies (knowledge) are those competencies that are needed to make a judgment about changes in a student's behavior or condition. These would include information such as the signs and symptoms of illness or problems. Persons trained in informational competencies are not required to take overt actions in implementing a procedure or intervention, but are trained to identify situations where the need for overt actions or intervention by trained personnel is needed and to seek appropriate means for intervention. All school personnel who work with the student require training in specific informational competencies in addition to the provision of training in general information, as previously described. These persons may include classroom teachers, special education teachers, teacher assistants, related services personnel involved with the child, school principal, librarian, physical education teacher, music teacher, etc., the child's peers and friends, and any others who need to know this information.

Performance competencies (skills) are those competencies where overt actions are being taught to and performed by trained personnel. These competencies refer to the actual administering of special health care procedures or interventions for a specific child. Training of district personnel and monitoring of their performance in implementing health care procedures must be provided by a licensed health care provider. Hence, the actual training of unlicensed school personnel may be provided by the child's physician, a school nurse, or districts may contract for the training through a home health care agency, hospital, or other health care facility. The training may be provided in the school or in a setting outside the school. In either case, the training must be conducted "hands on" with the actual student who requires the procedure. **Parents cannot serve as primary trainers to train unlicensed school personnel to perform health care procedures.** However, the parent is an integral part of the training since parents can provide a wealth of information on individual adjustments that can be included to make administering the procedure more efficient, effective, and more comfortable for their child.

Training unlicensed school personnel in performance competencies must be provided by a qualified trainer, which is defined as a licensed health care professional who possesses the knowledge and skills necessary to teach the performance of the health care procedure or intervention to others. Do not assume that an individual with a health care discipline label (e.g., nurse, school nurse, physician, etc.) possesses the knowledge, skills, and experience in a particular health care procedure or intervention that a student may require. Thus, programs that do have a school nurse may have to obtain additional training for the individual related to the health care procedure that is required. Programs that do not have a school nurse will need to locate a licensed health care professional who has the knowledge, skills, and experience in providing the required health care intervention and obtain the professional's services to make appropriate delegatory decisions, train unlicensed school personnel, verify their competency in performing the intervention(s) in a safe, effective manner, monitor the quality of the health care services provided for the student, and supervise the performance of the procedure. Part B funds may be used for provision of health care services for students who require the services as a direct result of the student's educational disability (qualify for special education services).

The Program Planning and Training Form contained in Appendix E can be used to document the steps in the procedure and is signed by both the physician and the parent(s) or guardian. This program plan then becomes the training form and used to document the individualized training (see Program Plan and Training Form in Appendix E). Quality training of unlicensed school personnel involves:

1. explanation and demonstration of the procedure by the trainer,

2. observation of the trainee performing the procedure,

3. feedback from the trainer to the trainee on his or her performance of the steps involved in the procedure,

4. verification by the trainer that trainee has reached criterion (defined as performance of 100% of the steps correctly without prompts or cues [hints or assistance] from the trainer over a specified number of training sessions),

5. monitoring the newly trained personnel periodically to insure that they continue to perform the procedure correctly, and verifying the trained personnel can identify when additional consultant, training and/or resources are needed in the provision of services,

6. conducting the training in a manner that preserves the student's privacy and dignity at all times during sessions and thereafter, particularly during the procedures of colostomy and ileostomy care, and catheterization.

When health care procedures must be performed at school, always train at least three persons in the school (building). If only one person is trained to perform the procedure, there is no back-up plan or substitute if the sole trained person is absent or unavailable. This rule also applies to training of transportation personnel or teacher assistants who accompany students on the school bus, if these procedures are required during transit (e.g. suctioning).

In some cases, parents have been employed by the school district to come to the school at a scheduled time during the day to perform the health care procedure (e.g. catheterization). If this is necessary, caution is taken to ensure that parents and children do not become overly dependent on each other or that a parent's presence at school does not further isolate or stigmatize the student. The same caution is taken when the child's parent is employed full time as an assistant for the student. In these cases, it is recommended that the parent would work with all the children in the class, not just their son or daughter. This would be true for any assistant or teacher's aide assigned to work with a student. The reasons for caution in these cases is that we want to a) promote healthy separation of child and parent from each other, b) increase the probability that the child learns to work with other adults and interact with children his or her own age, and c) reduce the possibility of further stigmatization that may occur because the child's parent (or any other specific adult) is always with them.

When school district personnel first encounter students who require special health care procedures, district staff are usually concerned with liability. However, liability is not the issue, because we are all liable for everything we do in the educational setting. The real issue is negligence. If districts follow appropriate planning and training procedures and regularly monitor the child's program, they have taken all known precautions. It is critical to note that negligence exists only if school personnel act in an unreasonable or imprudent manner.

Other training needs. It may prove prudent for a school district to train most or all its personnel in first aid, school health policies and procedures, universal precautions to prevent the spread of illnesses and communicable diseases, cardiopulmonary resuscitation (CPR), first aid, and such things as seizure monitoring, and other pertinent information related to the special health care needs of the children they serve. Education and training of staff can go a long way to diffuse very emotionally laden issues as they arise in the future. Unfortunately, the usual immediate response of most staff in dealing with students with special health care needs is fright and an attitude of "that's not within my job scope or responsibility". By providing some training of a general nature (in advance) to all staff before individual cases arise, we can prevent some of these fears and concerns from developing later on when the need for special health care arises. These types of trainings and staff development activities are excellent for all staff in terms of general knowledge and awareness. Appendices F through H include examples of general training information that should be provided to all school staff, and appendices I through L contain additional training materials, readings, and resources related to providing services to students with special health care needs.

Emergency Procedures

Two types of emergency procedures must be planned and documented when working with children with special health care needs. First, emergency procedures must be planned in case of illness, accident, or life-threatening situations. Parents must provide written instructions for how to deal with these situations. This includes what to do and who to notify in case of emergency including such information as physician's name and how to contact him or her, emergency medical assistance (emergency medical team, ambulance service, emergency room and what hospital), insurance type and policy number,-at least two persons to contact and in what order to call them (e.g. parent(s), other family members, neighbors), and what to do if no one on the contact list can be reached. This information is place on file, located by the telephone for easy reference, and taken on off-campus school activities (e.g. community-based instruction, class trips). It is helpful to contact and alert the local emergency medical assistance (resue units) and the hospital of choice before their services are needed as part of the emergency plan.

The second type of emergency procedures relate to the occurrence of fire or natural disasters (e.g. tornados, earth quakes) and possible equipment problems due to power outage or failure (e.g. child requires operated equipment powered by electricity or batteries). Building escape routes and procedures are reviewed to determine if special evacuation procedures or emergency provisions are needed for the child with special health care needs. If the child uses equipment that is operated by electricity or batteries, is there a battery-operated or manual back-up device (e.g. suctioning machine, respirator)? If the child uses a wheelchair and attends a class on the second floor of the school, how will they be transported downstairs during fire drills when the elevator is inoperable? These are all questions that must be answered to develop plans to handle these situations safely and efficiently in the school environment.

Transportation Issues

Admissions and Release Committees need to consider the following transportation issues, document them on the IEP, and review them on a periodic basis:

1. mode of transportation to and from school (e.g. school bus, van, parent transport),
2. length of time on vehicle one way,
3. equipment and/or adaptations necessary for transportation,
4. evacuation procedures during transit in case of fire or accident,
5. need for bus aides,
6. driver and/or bus aid training, and
7. protocols for on-board health care procedures delivered during transit.

Depending on the specific health care need of the child, the school district may need to provide this service during transit. When intervention is required during transit (e.g. seizure monitoring, suctioning), the school bus staff must be well trained to deal with these situations. They may be trained in conjunction with other school staff being trained by the licensed health care professional consulting on the child's case. This training is documented and procedures monitored by the professional (Refer to the previous section on training). Always have more than one person trained who can provide services during transport. This back-up plan will be critical when trained staff are absent. The other person trained could be the van driver, another teacher aid that could serve as the back-up transport staff, or the child's teacher could serve in this role.

There must be clearly written procedures for transportation personnel that include who has been trained to administer the procedure, what the procedure involves (including signs and symptoms of problems), guidelines for documenting the administration of procedures or incidents, and procedures to handle emergencies that may occur in transit including evacuation procedures. On going training and consultation between transportation staff and school staff is critical. On going communication between educational staff, parents, and transportation staff needs to be provided on a daily basis. One source of sharing information is the written record of procedures administered. Refer to the sections on training and emergency procedures for additional information pertinent to transportation issues. The same documentation procedures and training model used with teachers can be used for transportation personnel.

In some cases, a transportation aid or even a nurse may be needed to ride the vehicle. Special equipment, such as a suction machine, may need to be used on a transportation vehicle. Decisions about who provides and maintains the equipment, is documented on the IEP.

Length of time in transit is also considered. Information is obtained from the physician about the maximum length of time in transit that the child can tolerate comfortably and safely. Whenever possible, children with special health care needs can and do attend their neighborhood school (the school closest to their home). This reduces the amount of transportation time involved and thus, may reduce or eliminate the need for procedures to be administered by transportation staff during transit.

Summary and Recommendations

The purpose of this document was to provide school district personnel with guidance in providing services for students with special health care needs. Information regarding the definitions related Kentucky regulations, and results of the Kentucky survey of teachers has been included to further understand the related issues and needs in Kentucky. The belief statements included lay the foundation upon which quality services should be designed and implemented. The sections that address placement and IEP development, provision of related services, training unlicensed school personnel, emergency procedures, and transportation issues provide a discussion of the related issues and recommendations in regards to implementation.

We hope that this document is both informative and useful for administrators, service providers, parents, and persons involved in policy making and training. It is recommended that this document be used to design and provide quality services for students with special health care needs in local school districts. In addition, the information contained within should be incorporated into staff development plans and personnel preparation programs at Kentucky's colleges and universities. We encourage the duplication, dissemination, and use of the related training materials and forms contained in the appendices section. Your reactions and suggestions related to the content of this document and accompanying materials are welcomed and appreciated.

References

Bevin, H. by Michael H. v. Wright, 666 F. Supp. 71 (W. D. Penn. 1987).

Coucil for Exceptional Children's Ad Hoc Committe on Medically Fragile Students (1988). *Report of the council for exceptional children's ad hoc committee on medically fragile students.* Reston, VA: Council for Exceptional Children.

Department of Education, State of Hawaii v. Dorr, 727 F.2d 809 (9th Cir. 1983).

Detsel by Detsel v. Board of Education of Auburn, 637 F. Supp. 1022 (N. D. N. Y. 1986).

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). *Health care for students with disabilities: An illustrated medical guide for the classroom.* Baltimore: Paul H. Brookes.

Irving Independent School District v. Tatro, 104 S. Ct. 3371 (U. S. Sup. Ct. 1984).

Kentucky Board of Nursing (1990). *Kentucky nursing laws.* Charlottesville, VA: The Michie Company.

Kentucky Department of Education (1990). *School health services manual.* Frankfort, KY: Author.

Lehr, D. H., & Noonan, M. J. (1989). Issues in the education of students with complex health care needs. In F. Brown & D. H. Lehr (Eds.), *Persons with profound disabilities: Issues and practices* (pp. 139-160). Baltimore: Paul H. Brookes.

Lyon, S., & Lyon, G. (1980). Team functioning and staff development: A role release approach to providing integrated educational services for severely handicapped students. *Journal of the Association for Persons with Severe Disabilities*, 5(3), 250-263.

Mulligan-Ault, M., Guess, D., Struth, L., & Thompson, B. (1988). The implementation of health-related procedures in classrooms for students with severe multiple impairments. *Journal of the Association for Persons with Severe Disabilities*, 13(2), 100-109.

Smith, P. D., Leatherby, J. L., & Wasson, T. H. (1991). *Delivery of health maintenance procedures to students with complex health care needs in Kentucky.* Unpublished manuscript, University of Kentucky, Interdisciplinary Human Development Institute, Kentucky Systems Change Project, Lexington.

Task Force on Children with Special Health Care Needs (1988). *Recommendations: Services for children with special health care needs.* Des Moines: Iowa Department of Education.

The Joint Task Force for the Management of Children with Special Health Care Needs of the American Federation of Teachers, Council for Exceptional Children, National Association of School Nurses, & National Education Association (1990). *Guidelines for the delineation of roles and responsibilities for the safe delivery of specialized health care in the educational setting.* Reston, VA: Council for Exceptional Children.

APPENDIX A

Recommendations for Dealing with Specific Health Care Procedures

SPECIFIC HEALTH CARE PROCEDURES

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The purpose of this section of the document is to provide school district personnel guidance in planning health care services and needed training for working with students with special health care needs. The information provided is general in nature and should not be viewed as a substitute for appropriate training. (See section entitled "Training Unlicensed School Personnel to Perform Special Health Care Procedures" in the narrative portion of this document for information related to training procedures.)

The specific health care procedures are acts generally considered nursing care activities which are provided by a nurse or provided only by a designated trained person(s) for an individual student as delegated by, and under the supervision of a nurse. (See section entitled "Related Kentucky Regulations" in the narrative portion of this document - Pg. 10).

Other licensed health care providers such as physicians, physical therapist, occupational therapist, or speech/language therapist may provide, delegate, teach and supervise others in the performance of procedures, when the procedures are within the scope of practice of the given licensee. The following health related procedures are included in this section:

Administering Medications

Cast Care and Monitoring

Catheterization

Gastrostomy Tube Feeding

Glucose Monitoring (Diabetes)

Ileostomy/Colostomy Care

Nasogastric Tube Feeding

Seizure Intervention and Monitoring

Tracheostomy Care and Suctioning (including oral suctioning)

Ventilator Dependent

ADMINISTERING MEDICATION

Description: Children may receive a variety of medications at school. Medications may be administered in a variety of ways including orally, rectally, etc. Students may need to take medications for both acute illnesses and chronic conditions. Acute illnesses result in medication being given for an illness that will last only a few days or weeks. Children with chronic conditions such as epilepsy will possibly have to take medication on a continual basis.

Recommendations

- All medications given via any injection route should be given by a licensed health care professional. Additionally, medications given via nasogastric tube must also be administered by a licensed health care professional.

- Consult with the physician and parents about the type of medication that must be administered and a complete description including:

  - dosage,
  - when the medication must be given,
  - how the medication will be given (e.g., oral, rectal, NG tube, injection, etc.),
  - special considerations in administering the medication (e.g., medication given with or without food),
  - potential side-effects of the medication,
  - the length of time the child has been on the medication before returning to school and how long the child will be on the medication, and
  - how the medication will be prepared (e.g. crushed, mixed with food, etc.).

- If the method of the administering the medication requires any unusual procedures, the teaching staff should be trained by qualified licensed health care professional to administer the medication.

- Know signs and symptoms of side effects of medications and make plans in advance to deal with any complications.

- Consult with parents to design a plan for emergencies that may result from both the direct side effects of the medication or emergencies related to the administration of the drug. These may include:

  - physical or behavioral side effects of the medication,
  - physical or behavioral symptoms that indicate that the medication is not
  - being properly absorbed into the child's bloodstream,
  - entire dosage of medication was not ingested by the child,
  - the child received the incorrect medication, and
  - the child choked while being administered the medication.

Documentation

- Document treatment recommendations as specified by the physician with the parental consent.
- Document emergency procedures as planned in conjunction with parents.
- Document training by qualified licensed health care professional for school personnel who administer the medication (where applicable).
- Review and/or develop district policies that include a checklist of procedures for the prevention of giving the wrong medication to a student including:
    - medication was delivered in original container,
    - medication was properly labeled with student's name, and
    - medication was stored properly (in a locked storage cabinet) so that it is not accessible to other students.
- Daily record of medication administration (copy sent to parents daily) that includes:
    - time medication was given,
    - method of administration,
    - dosage of medication,
    - any side effect from the medication, and
    - responses to medication(s) (e.g., drowsiness, hyperactivity, nausea).
- Use Authorization to Give Medication form and Medication Administration Record in Appendix D.

Precautions

- One person should be responsible for the entire process of administering the medication to a given student to reduce the risk of improper dosages or wrong medications being given. In other words, if one person retrieves the medication from storage and measures the dosage, that person should also administer the medication.
- The first dosage of a new medication or a change in dosage of a current medication should not be given at school.
- Medicine spoons should be used to assure that the dosage of liquid medications given to the student is as accurate as possible.
- Students with oral motor and feeding difficulties will also have difficulty taking oral medications. The students are at a greater risk or choking during the administration of the medication.

- The administration of improper medications should be reported immediately to the student's physician and the parents.

- School staff who are unsure of the side effects of a particular medication should consult a nurse, pharmacist, or physician.

Recommended Readings and Resources

Physician's Desk Reference or Nurse's Drug Book

Gadow, K. D. (1979). Children on medication: A primer for school personnel. Reston, VA: Council for Exceptional Children.

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 3: Medication Administration)

CAST CARE

Description: Casts are generally made of plaster of Paris. Students most often wear casts to immobilize a broken or fractured bone. Students with physical disabilities may wear casts due to joint dislocations or to prevent or correct body deformities such as scoliosis.

Recommendations

- Consult with the physician and parents about the type of cast and complete description including:
  - type of cast (may be plaster of Paris or fiberglass),
  - how long the student will have to wear the cast before the injury heals,
  - the reason the child is wearing the cast (e.g. orthopedic surgery or bone fracture),
  - how long the child has had the cast, and
  - special positions needed due to cast (i.e., leg elevation).
- Know the signs and symptoms of complications that might arise and make plans in advance to deal with these.
- Know the signs, symptoms, and complaints that may indicate cast problems including swelling, blueness of extremities (fingers, toes), complaints of pain, and complaint of burning sensation.
- Consult with parents to design a plan for conditions or emergencies that may result from wearing cast. These may include:
  - indentations in a new cast,
  - skin breakdown around or under the cast, and
  - conditions that indicate that the cast is too tight or rubbing (redness).

Documentation

- Document emergency procedures as planned with parents
- Document treatment recommendations as specified by the physician with parental consent. Physical and occupational therapists can also provide assistance in interpreting and implementing cast care recommendations. These may include:
  - cleaning the cast,
  - assisting the student with a cast in toileting activities,
  - checking the condition of the skin around and underneath the cast, and
  - checking for the continued correct positioning of the cast.

- Documented training by qualified licensed health care professional for school personnel who perform cast care (e.g. nurse, physical or occupational therapist).

- Maintain daily treatment record (sent to parents) for the duration that the cast is applied, particularly during the first two to three weeks that includes:
    - documentation that cast was checked for pressure sores or skin
    - breakdown during day,
    - record of any skin irritation that was discovered and treatment method,
    - time of elimination, if relevant to type of cast, and
    - documentation of any sign of poor circulation.

- Use or adapt for use Health Care Services Record form in Appendix D.

Precautions

- Care should be given to protect the cast from the following:
    - indentations (especially when the cast is new),
    - soiling from food, drink, urine, or feces, and
    - dropping small objects or pieces of food down in the cast.

- Prevent pressure sores and skin breakdowns can be reduced by repositioning the student at regular intervals, per physician and/or therpist's recommendations.

- Closely observe the student's skin condition and circulation during the time the student is wearing the cast. Repeated complaints of discomfort by the student should be reported to the child's parents and the school nurse or other licensed health care provider, and/or the child's physician.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 10: Cast Care)

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CATHETERIZATION

Description: The purpose of catheterization is to drain urine from the bladder via insertion of a catheter (flexible tube). Catheterization may be necessary for reasons such as injury to the bladder, paralysis of bladder functioning, and acquired disease. Types of catheter systems include indwelling catheters with external collection bag and clean intermittent catheterization.

Indwelling Catheters: Indwelling catheters are the type that are frequently used in hospitals for patients receiving surgery. The catheter is inserted and remains in the bladder. Urine drains into a collection bag. Condom catheters are one type of catheter used by males that fit over the penis and urine drains into a collection bag strapped to the leg. Indwelling catheters are usually used as a temporary solution for bladder control since their presence over time increases the likelihood of urinary infections.

Clean Intermittent Catheterization: This catheterization method involves draining the urine from the bladder on a specified schedule (e.g., every 2 to 4 hours, or sometimes every 6 to 8 hours). The catheter does not remain indwelling, but is inserted each time the bladder is drained. (Sterile intermittent catheterization should be administered by licensed health care professional.)

Recommendations

- All catheterization should take place in a private area. Students who can stand over or sit unassisted on a toilet may learn to catheterize themselves and do this in the regular restroom. Other students will require a room or private area to provide optimal privacy for the student. A high degree of sensitivity is demonstrated by the person performing the procedure due to the possibility of embarrassment to the student. Ideally, the room should contain a sink so that hand washing facilities are available. Always have supplies organized prior to performing the procedure.

- Obtain training to perform procedure from qualified licensed health care professional working directly with the student during training sessions.

- Consult with the child's physician regarding frequency (schedule) of intermittent catheterization and to determine if urine amount is to be recorded.

- Know signs and symptoms of urinary tract infections and problems (e.g. unusual color or odor of urine, presence of blood in the urine, fever, pain or burning in students without paralysis).

- Encourage adequate intake of fluids and monitor fluid intake and implement recommendations as specified by physician.

Documentation

- Document treatment recommendations as specified by the physician with parental consent including:
    - authorization form signed by parents and physician (see Appendix D),
    - specifications about type of catheterization (clean or sterile techniques),
    - schedule of times to be conducted, and
    - amount of urine eliminated if required to be measured.
- Maintain daily treatment record (sent to parents) that includes:
    - times catheterization occurred,
    - amount of urine (if required),
    - who conducted,
    - evidence of urinary tract infection, and
    - amounts of liquids given.
- Document emergency procedures as planned in conjunction with parents.
- Document training by a qualified licensed health care professional for unlicensed school personnel who perform catheterizations (use Program Plan and Training Form in Appendix E)
- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

Precautions

- Wear vinyl or latex gloves when performing catheterization. However, many children with spina bifida are allergic to latex and require the use of vinyl gloves during catheterization or any other procedure where they are required. Consult with the physician regarding the type of gloves to use.
- Regular testing of nitrates in urine may be required for some students.
- Follow appropriate procedures for the disposal of body fluids (urine) as specified in Appendix G.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 15: Clean Intermittent Catheterization)

GASTROSTOMY TUBE FEEDING

Description: Used to provide supplemental or total nutrition via a tube surgically placed into the stomach called a gastrostomy tube (G-tube). There are three types of feeding methods: 1) bolus (formula is allowed to flow through the G-tube within a few minutes, 2) drip method with external feeding bag (formula drips slowly over a specified period of time), and 3) drip method with external feeding bag on a time regulated pump (formula drips slowly throughout the day and/or night, regulated by pump).

Recommendations

- Consult with physician and parents about type of method used and complete description including:
    - amount of feeding,
    - name of liquid formula,
    - rate of delivery of formula,
    - positioning of student during feeding,
    - length of time after feeding before child can be placed in a reclined position, and
    - any special considerations.

- Be trained by qualified licensed health care professional to perform the specified G-tube feeding for an individual student. This includes aspiration procedures if required.

- Know oral stimulation or oral feeding procedures and/or contradictors (see Feeding Disorders in Appendix B).

- Know signs and symptoms of problems that might arise and make plans in advance to deal with these.

- Consult with parents to design a plan if and when G-tube comes out or is accidentally pulled out. The student's parents or a licensed health care professional must reinsert the tube. Unlicensed school personnel should not be trained to perform this function.

Documentation

- Document treatments and recommendations as specified by the physician with parental consent.

- Document emergency procedures as planned in conjunction with the parents.

- Maintain daily treatment record for each student (copy sent to parents daily) including:

- time and date feeding was given,
- type and amount of formula,
- amount of water given,
- physical reactions (e.g. vomiting), and
- initials and identifying signature of person completing record.

* Document training by qualified licensed health care professional for unlicensed school personnel who perform procedure (use Program Plan and Training Form in Appendix E).

* Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

Precautions

* Wear latex gloves when coming in direct contact with G-tube and stoma area.

* Have plan in the event the G-tube becomes displaced. Only a nurse or the child's parents can reinsert the tube.

* Consult with the physician to clarify positioning of the student while feeding and after feeding takes place.

* Obtain release and recommendations from the physician for positioning any student with a G-tube in a prone position (lying on stomach).

* Observe the student closely during feeding and discontinue if the child displays excessive sweating, begins to vomit, coughs or chokes, or appears uncomfortable.

* The nutritional value of some formulas may be altered by adding certain medications. Be aware of what medications are permissible to be mixed with the particular formula being used.

* Watch for signs that the student is not tolerating the formula, such as, vomiting, diarrhea, and excessive gas; and report these to the parents and/or health care professional.

* Watch for signs of skin irritation around the stoma.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 14: Gastrostomy Tube Feeding)

P.D. Smith & J. L. Leatherby (1991)
Services for Children with Special Health Care Needs
Kentucky Systems Change Project
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GLUCOSE MONITORING (DIABETES)

Description: Students who are diabetic, meaning that they have an excess of glucose or sugar in their bloodstream, may require glucose monitoring during school hours. Glucose monitoring simply means testing the amount of sugar in the bloodstream at regular intervals. It may be accomplished by sampling urine or blood for its sugar content. According to Graff, et al. (1990), testing the blood is the method of choice. However, glucose monitoring may be accomplished by sampling either urine or blood for sugar content.

Recommendations

- Consult with the physician and parents about the type of glucose monitoring procedure used (urine or blood) and obtain a complete description of the following:
    - what the ideal and acceptable blood sugar goals are and how that varies at certain times of day,
    - what the schedule is for glucose monitoring,
    - what method of glucose monitoring will be used,
    - how the amount of glucose in the blood or urine will be determined (i.e. visually or with a glucose monitoring device),
    - what signs and symptoms are of hypoglycemia (too little sugar) and hyperglycemia (too much sugar), and
    - any treatment recommendations related to hyperglycemia and hypoglycemia.
- Be trained by qualified licensed health care professional to perform glucose monitoring.
- Know signs and symptoms of complications that might arise and make plans in advance to deal with these.
- Consult with parents to design a plan for emergencies that may become apparent as a result of insulin therapy. These may include:
    - trauma to the part of the body that is continually pricked for blood tests,
    - increased insulin in bloodstream,
    - decreased insulin in bloodstream, and
    - coma resulting from too much insulin (insulin coma) or too much sugar (diabetic coma).
- Licensed health care professionals should periodically check and assure proper operation of glucose monitoring equipment.

Documentation

- Document treatment recommendations as specified by the physician with parental consent.

- Document emergency procedures as planned in conjunction with the parents.

- Document training by qualified licensed health care professional for unlicensed school personnel who perform procedures (see Program Plan and Training Form in Appendix E).

- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

- Maintain daily treatment record (copy sent to parents daily)
    - time and date of glucose monitoring and the results,
    - who performed the glucose monitoring (child or school personnel),
    - any evidence of trauma to skin on area where blood was taken,
    - report signs and symptoms of hypoglycemia or hyperglycemia to parents and health care provider, and
    - administration of any emergency procedures for hypoglycemia or hyperglycemia.

Precautions

- Signs of inadequate insulin coverage should be reported to the student's physician.

- Teachers having students who are nonspeaking and diabetic should be especially aware of the behavioral symptoms of hypoglycemia and hyperglycemia and what to do in response to these conditions.

Recommended Readings and Resources

Christiansen, R. O., & Hintz, R. L. (1982). Juvenile diabetes mellitus. In E. E. Bleck & D. A. Nagel (Eds.), Physically handicapped children: A medical atlas for teachers (2nd ed.) (pp.269-278). New York: Grune & Stratton.

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 11: Glucose Monitoring for the Student with Diabetes)

Winters, R. J. (1983). Childhood diabetes mellitus. In J. Umbreit (Ed.), Physical disabilities and health impairments: An introduction (pp.195-205). New York: Macmillan Publishing Co.

Juvenile Diabetes Foundation (see Appendix J)

P.D. Smith & J. L. Leatherby (1991)
Services for Children with Special Health Care Needs
Kentucky Systems Change Project
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ILEOSTOMY AND COLOSTOMY

Description: Methods by which feces are eliminated when a person has an obstruction in the intestines which prevents normal flow of fecal matter. A colostomy results in some portion of the large intestine being brought through the abdominal wall. Fecal matter is irrigated through a stoma or opening in the abdomen. A portion of the small intestine is brought through the abdominal wall when the ileostomy is performed. A pouch is worn on the outside of the abdomen to collect the fecal matter.

Recommendations

- Consult with the physician and parents about type of ostomy and complete description including:
    - location of the ileostomy or colostomy,
    - frequency of elimination,
    - special diet modifications,
    - consistency of the feces,
    - medications used on the ostomy,
    - type of collection pouch used,
    - procedures for changing pouch, and
    - supplies needed for changing pouch.
- Unlicensed school personnel must be trained by qualified licensed health care professional to perform ostomy care.
- Know signs and symptoms of complications that might arise and make plans in advance to deal with these.
- Consult with parents to design a plan for emergencies that may result from ileostomy/colostomy care. These may include:
    - blockage of the intestine that may result in cramping, vomiting, etc.,
    - dehydration from persistent diarrhea,
    - bleeding from the stoma, and
    - skin breakdown around the stoma.

Documentation

- Document treatment recommendation as specified by the physician with parental consent.
- Document emergency procedures as planned in conjunction with the parents.
- Document training by a qualified licensed health care professional for unlicensed school personnel who perform ostomy related care (use Program Plan and Training Form in Appendix E).

- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

- Maintain daily treatment record (copy sent parents daily) including:

  - time and date of elimination(s),
  - consistency/color of fecal matter,
  - variations in diet for the day,
  - unusual discharge from stoma,
  - skin irritations observed,
  - medications applied to skin irritations, and
  - note if collection bag had to be replaced and why.

Precautions

- If collection bag is closed with a clamp, prevent child from lying on clamp which could result in injury.

- An adequate supply of collection pouches and other materials should be kept on hand in case of leakage.

- Care should be given to protect the student's privacy when providing ileostomy or colostomy care.

- Wear vinyl or latex gloves when performing providing ileostomy/colostomy care or coming in contact with the stoma. However, many children with spina bifida are allergic to latex and require the use of vinyl gloves. Consult with the physician regarding the type of gloves to use.

- Use appropriate sanitation practices when caring for ileostomy/colostomy including hand washing and use of deodorant sprays when changing collection bag.

- In cases where the student has an excessive amount of gas, special diet considerations may be required.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 12: Colostomy or Ileostomy Care)

NASOGASTRIC TUBE FEEDING

Description: Used to provide supplemental or total nutrition via a tube that is inserted into the nose and leads to the stomach. Nasogastric (NG) tube feeding is intended to be a short-term intervention for children with feeding difficulties. There are four types of feeding methods: 1) bolus (formula is allowed to flow through the NG-tube within a few minutes), 2) intermittent gravity drip method (formula drips slowly from a hanging container in 20-30 minutes, 3) continuous gravity drip method (formula is dripped slowly over a period of 16-24 hours), and 4) continuous infusion by pump method (formula is dripped slowly throughout the day and/or night, regulated by pump).

Recommendations

- Consult with the physician and parents about type of feeding method used and complete description including:
    - amount of feeding,
    - name of liquid formula,
    - rate of delivery of formula,
    - preferred method of checking tube placement,
    - daily care requirements of NG tube,
    - length of time after feeding before child can be placed in reclined position, and
    - any special considerations.
- **Only licensed health care professionals can provide NG tube feedings and administer medications via this route.** The designated licensed health care professional should obtain training to perform the specified NG tube procedure for an individual student. This includes aspiration procedures, if required.
- Know oral stimulation recommendations or oral feeding procedures and/or contradictions (see Feeding Disorders in Appendix B).
- Know signs and symptoms of problems that might arise and make plans in advance to deal with these.
- Consult with the parents to design a plan if and when the NG tube slips up or is accidentally pulled out from the stomach into the esophagus.
- A nurse or parent should be responsible for inserting/reinserting the NG tube.

Documentation

- Document treatment and recommendations as specified by the physician with parental consent.

- Document emergency procedures as planned in conjunction with the parents.

- Maintain daily treatment record (copy sent to parents daily):

  - time and date feeding was given,
  - method of determining that tube is in place,
  - type and amount of formula given,
  - amount of water given,
  - physical reactions (e.g. vomiting), and
  - initials and identifying signature of person completing record.

- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

Precautions

- The nutritional value of some formulas may be altered by adding certain medications. Be aware of what medications are permissible to be mixed with the particular formula being used. (Only licensed health care professionals can perform NG tube feedings or administer medications via this route.)

- Watch for signs that the student is not tolerating the formula such as vomiting, diarrhea, excessive gas, etc.

- NG tubes may become plugged or clogged and not allow the formula to pass through the tube. Be aware of procedures for removing whatever is obstructing the tube.

- Watch for signs of skin irritation where the tube is taped to the child's face or in the child's nostril.

- Feeding should be discontinued if the NG tube slips up from the stomach into the esophagus.

- Wear vinyl or latex gloves when having direct contact with the NG tube.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 13: Nasogastric Tube Feeding)

SEIZURES

Description: Seizures are characterized by involuntary motor activity or a change in consciousness. A seizure occurs when bursts of unorganized electrical impulses interfere with normal brain functioning. Epilepsy is a chronic condition of the nervous system and involves recurrent seizures. While recognizing the 1981 International Classification of Epileptic Seizures, types of seizures generally used in schools include: (a comparison may be found on Page 50.)

Petit Mal - may have a variety of small movements, momentary and partial loss of consciousness, sometimes difficult to observe, may appear to resemble inattentiveness or daydreaming, may have several in succession;

Psychomotor - repetitive motor act such as twisting button of shirt, clicking of tongue, partial loss of consciousness, confusion and disorientation;

Grand Mal - physical movements of the whole body (convulsions, tonic-clonic), loss of consciousness, may be loss of bladder and/or bowel control, usually experience fatigue after seizure and may need to rest or sleep;

Akinetic or Drop - loss of consciousness, fall to floor, length of seizure varies.

Focal - rhythmic eye movement, some head turning, usually short in duration (less than 30 seconds), often seen in students who are very physically limited; and

Recommendations

- Obtain information from parents about student's seizure activity including:
    - type(s) of seizures,
    - frequency,
    - typical behavior or signs prior to occurrence of seizure,
    - usual treatment during and after seizure,
    - name of medication(s) taken, dosage, times given (see section on administering medications),
    - name and telephone number of physician,
    - name, telephone number, and location of hospital in case of emergency, and
    - need for helmet for student to prevent injury in case of atonic or drop seizures and severe grand mal seizures.
- Have knowledge of intervention practices for **Grand Mal** seizures:
    - Try to protect the student from injury by breaking fall or assisting student to floor and remove any furniture or objects that might fall on the student.
    - Do not restrain the student's physical movements.
    - Position the student on their side to allow any saliva or vomitus to drain out

  to the side and to maintain an open airway.
  - Do not place anything in the student's mouth.
  - Stay with the student during the seizure.

* After a seizure, the student may be tired and sleepy, confused, agitated or aggressive, and may require a change of clothing if incontinent. Reassure the student and try to dispel any anxiety they may be experiencing. Allow the student to rest or sleep, if needed.

Documentation

* Maintain a seizure record for each student who has seizures and include the following information for each seizure record (see Appendix D):

  - duration of seizure,
  - conditions or behaviors that preceded the seizure (e.g. bright or flashing lights, sounds, student's facial expression or physical movements and behavior),
  - description of physical movements during seizure, (e.g. jerking extremities)
  - description of other behaviors during seizure (e.g. smacking of lips, behavioral changes, facial color or expression changes, any respiratory distress, incontinence, etc.),
  - intervention after the seizure (e.g. allowed to rest, changed clothing, etc.), and
  - if child went to hospital, document efforts to notify parents.

* Document emergency procedures (if needed for an individual student) as planned in conjunction with the parents.

* Use suggested Seizure Record in Appendix D or similar form that clearly documents symptomatology of seizure.

Precautions

* Prolonged grand mal seizure activity is called status epilepticus and can be life threatening. If grand mal seizure activity continues for more than 10 minutes:

  - Summon an ambulance and have the student transported to the hospital for emergency treatment.
  - Notify the student's parents by phone and notify the hospital by phone so that they can anticipate the student's arrival.

International classification	*Previous label*
Generalized seizures	**Generalized seizures**
Absence	Petit mal
Myoclonic	Minor motor
Tonic-clonic	Grand mal
Atonic	Akinetic, drop attacks
Partial seizures	**Focal seizures**
Simple partial with more symptoms	Jacksonian seizures
Complex partial seizures	Psychomotor seizures
	Temporal lobe seizures

Source: Commission on Classification and Terminology of the International League Against Epilepsy (1981).

Recommended Readings and Resources

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 1: Seizure Monitoring)

Berg, B. O. (1982). Convulsive disorders. In E. E. Bleck & D. A. Nagel (Eds.), Physically handicapped children: A medical atlas for teachers (2nd ed.) (pp. 171-180). New York: Grune & Stratton.

Nealis, J. G. (1983). Epilepsy. In J. Umbreit (Ed.), Physical disabilities and health impairments: An introduction (pp.74-85). New York: Macmillan Publishing Co.

Epilepsy Foundation of America (see Appendix J)

TRACHEOSTOMY CARE AND SUCTIONING
(including oral suctioning)

Description: A tracheostomy is a surgical opening (stoma) made into the trachea (wind pipe, airway) to permit air movement in and out of the lungs. This may be needed for various reasons such as to bypass an area of obstruction, to relieve acute or chronic respiratory distress, as an adjunct to surgical procedures of the face and neck, and many other reasons. A plastic or metal tracheostomy tube is secured in place by cotton ties (string) around the neck. Student breathes through the tube instead of the mouth or nose. Suctioning is a procedure used to remove mucus from the tracheostomy tube or from the mouth and back of throat (oral suctioning). For oral suctioning, some students require this on a routine or regular basis during the day. Other students may require oral suctioning only in extreme emergencies (e.g. excessive vomiting after a seizure).

Recommendations

- Consult with the physician and parents about the type of method used and the student's needs including the following:

    - frequency that suctioning is needed,
    - appropriate positioning of student during suctioning,
    - provision of suctioning machine for use at school (electric or battery-operated),
    - provision of DeLee suction catheter to be used during transport, in the community, and in case of power loss (nonelectric), and
    - responsibilities of and training for school personnel.

- School personnel may require training in several or all of the following:

    - removal of secretions from the trachea (suctioning) or removal of secretions from the mouth and back of throat (oral suctioning),
    - cleaning the inner portion of the tracheostomy (needed at least 2 or 3 times per day including being done at home or more frequently),
    - cleaning and care of the skin around the stoma,
    - changing tracheostomy ties (done at least once per day and usually at home, may become soiled and need changing at school), and
    - reinserting and/or changing tracheostomy tube. (School personnel must know how to reinsert the tube. Changing of the tube is usually done at home at least weekly.)

- All school staff who work directly with the student should be trained in how to suction (using suctioning machine and DeLee suction catheter) and how to reinsert the tracheostomy tube if it should accidentally be removed.

- Each suctioning should take no longer than 10-15 seconds and be followed by at least a 60 second rest period to allow for reoxygenation.

- Students may require more frequent suctioning if he or she has a cold other respiratory condition, and when respiratory rate is increased due to physical exertion or respiratory distress/problems.

- Some students may require suctioning prior to eating/feeding. Follow recommendations of physician, nurse, and/or parent.

- Signs that indicate a student's need for suctioning include (Perry, 1982):

  - restlessness and an inability to be calmed,
  - difficulty breathing and/or faster breathing,
  - a frightened expression,
  - flaring of the students nostrils,
  - pale or bluish color around the student's mouth, and/or
  - bubbles of mucus that are seen or heard at the opening of the tracheostomy tube.

Documentation

- Document treatment and recommendations from the physician and parents on how to suction student, frequency, and proper equipment use.

- Document authorization from parents to perform suctioning and other related tasks as may be needed during the school day.

- Maintain and record on daily treatment record including (copy sent to parents):

  - times suctioned,
  - amounts (scant, small, moderate, large, excessive),
  - color (note signs of infection),
  - blood in mucus,
  - saline instillation,
  - any other information related to the student's individual needs, special signs and symptoms, or individualized needs for transportation, and
  - need for replenishment of supplies at school.

- Document staff training by qualified licensed health care professional (use Program Plan and Training Form in Appendix E).

- Document emergency procedures as planned in conjunction with the parents.

- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

Precautions

- Know symptoms of respiratory distress (indicates need for track or oral suctioning) including:

  - bluish or grayish color of fingernails or toenails,

  - nasal flaring,
  - retraction around ribs,
  - facial color changes (see above under signs for need of suctioning),
  - anxious look on face,
  - restlessness,
  - sounds of mucus in airway,
  - increased respiratory and/or heart rate, and
  - excessive choking, vomiting, or aspiration (oral suctioning).

- Positioning requirements for track or oral suctioning are highly individualized for each student and should be recommended by the child's physician.

- When performing oral suctioning, aim for the excess mucus or vomitas. Do not aim/suction too far back in the throat so that the student's gag reflex is stimulated. Continued stimulation of the gag reflex may cause the student to lose it.

- Use vinyl or latex gloves when suctioning and/or coming in contact with mucus secretions.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 16: Tracheostomy Care)

VENTILATOR DEPENDENT

Description: Children are considered "ventilator dependent" if they require mechanical ventilation to sustain life. The student receives assistance with breathing through the ventilator via a tracheostomy tube. Reasons for why a child may be ventilator dependent include cardio vascular disorders, disorders of the nervous system including brain injuries and tumors, pulmonary disorders, metabolic disorders, and others including asthma, smoke inhalation and shock. The amount of time a person must remain on the ventilator each day varies from person to person.

Recommendations

* Consult with the physician and parents about the following:

- length of time child must be on ventilator each day,
- the reason the child requires mechanical ventilation,
- the feeding method and schedule of the student,
- appropriate positioning for the child, and
- brand names of equipment used.

* All school personnel working with a student who is ventilator dependent will require training in several or all of the following from qualified health care personnel:

- ventilator operation,
- tracheostomy care and suctioning (see previous section on tracheostomy care and suctioning),
- use of humidification,
- cardiopulmonary resuscitation from mouth to tracheostomy stoma,
- positioning,
- postural drainage,
- feeding techniques,
- special communication techniques and devices,
- manual ventilation with a resuscitation bag, and
- specific instructions for particular types of equipment (some brand names require specific training measures).

* Consult with parents and medical personnel to design a plan for emergencies that may occur. These may include:

- power outages (Back-up power sources should be identified. Power companies and fire departments should be notified there is a student on life sustaining equipment at the school so they can be prepared in the event of a power outage.),
- how to protect/cover the tracheostomy when the child is taken outside,
- what to do in the event that the tracheostomy site is obstructed,
- what to do in the event that the tracheostomy tube becomes displaced,
- recognize signs of respiratory distress including dyspnea, orthopnea,

retractions, nasal flaring, tachypnea, and cyanosis (report to parents),
  - what to do in the event of respiratory infections and recognize the symptoms of such infections, and
  - what to do in the event that bleeding occurs.

- Due to the complexity of the needs of students who are ventilator dependent, a nurse is required at school. This is considered a medical service (not a related service) and is usually paid for by the family's medical insurance or Medicaid.

Documentation

- Document procedures as planned in conjunction with the parents and medical personnel.

- Maintain daily observation records (copy sent to parents) including:

  - feeding records (see form in Appendix D)
  - any emergencies that occur including tracheostomy obstruction or displacement, power outage, respiratory difficulties, blood in mucus, and
  - record of length of time mechanical ventilator is activated (if student does not need continuous ventilation).

- Use Authorization for Treatment form and Special Health Care Services Record in Appendix D.

Precautions

- The ventilator must be plugged in when not mobile.

- An emergency generator must be available in the event of a power outage.

- Emergency calling system should be available in the classroom of a student who is ventilator dependent.

- Emergency numbers of the following people/agencies should be readily available: family members and friends (both home and work numbers); otolaryngologist, pediatrician, local hospital; local police, fire, or rescue squad; and utility company.

- A system should be developed for the child, whenever possible, to signal when in distress. If the child does not have the ability to signal, it is more imperative for caregivers to be aware of signs and symptoms of distress.

- Avoid clothing that may obstruct the tracheostomy or shed fibers should be avoided.

- Avoid getting anything in the tracheostomy.

- Not all students who are ventilator dependent are mentally handicapped. For that reason, placement in programs for students with mental handicaps should not automatically occur simply because those programs may have health care personnel readily available. The Admissions and Release Committee determines the appropriate placement for the student.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 16: Tracheostomy Care)

Newton, L., Chambers, H., Ruben, R. J., Jornsay, D., Liquori, J., Stein, R., & Lawrence, C. (1982). Home care of the pediatric patient with a tracheostomy. Ann Otol Rhinol Laryngol, 91, 633-640.

APPENDIX B

Recommendations for Dealing with Other Health Care Concerns

OTHER HEALTH CARE CONCERNS

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The purpose of this section of the document is to provide school district personnel guidance in planning health care services and needed training for working with students with special health care needs. The information provided is general in nature and should not be viewed as a substitute for appropriate training. (See section entitled "Training Unlicensed School Personnel to Perform Special Health Care Procedures" in the narrative portion of this document for information related to training procedures.) The following health related concerns are included in this section:

The specific health care procedures are acts generally considered nursing care activities which are provided by a nurse or provided only by a designated trained person(s) for an individual student as delegated by, and under the supervision of a nurse. (See section entitled "Related Kentucky Regulations" in the narrative portion of this document - Pg. 10).

Other licensed health care providers such as physicians, physical therapist, occupational therapist, or speech/language therapist may provide, delegate, teach and supervise others in the performance of procedures, when the procedures are within the scope of practice of the given licensee. The following health related procedures are included in this section:

Bone and Joint Deformities

Bowel Care

Congenital Heart Disease

Feeding Disorders

Nutrition

Orthotics Care (Braces and Splints)

Prosthetics Care (Artificial Limbs)

Shunt Monitoring

Skin Care

BONE AND JOINT DEFORMITIES

Description: Bone and joint deformities may result from restriction of movement of the muscles surrounding the bones and joints. Muscles surrounding joints, that do not maintain adequate range of motion, eventually shorten so that full range of motion is not possible. Permanent shortening of these muscles results in **contractures** of the joints. Inability to participate in normal movement activities can also lead to bone deformities due to the fact that bones become softer and less dense as a result of lack of movement. Lack of movement may also adversely effect other systems of the body including the respiratory system, urinary tract, the gastrointestinal system, and condition of the skin.

Recommendations

- Consult with a physical or occupational therapist and the student's orthopedic specialist about the types of therapeutic management techniques needed to prevent bone and joint deformities including a description of the following:
    - oint range of motion exercises,
    - joint range of motion techniques to integrate throughout the day,
    - variety of positions to place student in for educational activities,
    - handling techniques including specialized physical assistance, and
    - adaptive equipment.
- All personnel working with a student with bone and joint deformities are trained to perform therapeutic management techniques. Training is done by a qualified physical or occupational therapist who has experience working with students with physical and motor disabilities.
- Visual reminders (pictures) of appropriate handling and positioning techniques are obtained from the therapist(s) for school personnel to refer to at all times
- Know signs and symptoms of complications that might arise and make plans in advance to deal with these.
- Consult with the student's parents to design a plan for associated problems or emergencies that may occur. These may include:
    - pressure sores,
    - bone fractures, and
    - swelling or inflammation of joints.

Documentation

- Document treatment recommendations as specified by the physician and/or physical therapist with parental consent

- Document emergency procedures as planned in conjunction with parents.

- Document training by qualified personnel (e.g. physical therapist) for school personnel who perform positioning and physical management techniques.

- Document on going communication between physical therapist and school personnel in regard to changes in therapeutic management techniques.

- Weekly treatment record including:

    - frequency of range of motion exercises,
    - frequency of positioning changes as well as variations,
    - presence of redness, blanching, swelling, or bruising, and
    - any recommended changes in therapeutic management procedures by physical therapist.

- Use Positioning Requirements form in Appendix D to document positioning recommendations.

Precautions

- Obtain training from a physical therapist in the use of proper body mechanics when lifting, handling, or carrying students with physical disabilities.

- Range of motion exercises, handling techniques, and positioning **are not**, in and of themselves, educational goals for students with physical or motor disabilities. They are **physical management techniques** and should be included in all instructional activities in which the student participates.

- Equipment should be maintained for safety and proper fit for each individual student.

- Fractures and joint dislocations can occur during range of motion exercises. School personnel should be aware of the signs of this occurring.

- Signs of joint contractures should be reported to the physical or occupational therapist.

Recommended Readings

Campbell, P. H. (1987). Physical management and handling: Procedures for students with movement dysfunction. In M. E. Snell (Ed.), Systematic instruction of persons with severe handicaps (3rd ed.) (pp. 174-187). New York: Macmillan Publishing Co.

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 7: Therapeutic Management)

Lough, L. K. (1990). Positioning and handling. In J. A. Blackmon (Ed.), Medical aspects of developmentally disabilities in children birth to three (2nd ed.) (pp. 25-44). Rockville, MD: Aspen Publishers.

Word, D. E. (1984). Positioning the handicapped child for function (2nd ed.). Phoenix, AZ: Phoenix Press.

BOWEL CARE

Description: Children with certain medical conditions and/or motor disabilities may have problems with bowel regularity and elimination.

Recommendations

- Consult with the student's parent/guardian to obtain history of child's regular bowel habits.

- Know signs and symptoms of bowel problems (e.g. constipation, diarrhea, dehydration, hemorrhoids).

- Implement nutritional and fluid intake recommendations, and the use of laxatives, stool softeners, suppositories, or enemas as specified by physician.

- Promote practices that prevent bowel problems including ample fluid intake, and adequate fiber in diet.

- Determine if the child requires special positioning devices for toileting or the use of relaxation techniques to promote elimination. Consult with physical and/or occupational therapists for recommendations and/or training if needed.

Documentation

- Document treatments and recommendations as specified by the physician with parental consent.

- Maintain daily treatment record (copy sent to parents) including:

  - supplements given (if prescribed),
  - amount and frequency of fluid intake,
  - laxatives given (if prescribed), and
  - date and time of bowel movement.

Precautions

- Use vinyl or latex gloves when toileting children. (see Appendix G Preventing Transmission of Communicable Diseases)

- Students with motor disabilities may have impacted bowels, which require medical intervention.

Recommended Readings

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 5: Bowel Care)

Shaddix, T. (1986). Nutritional care for the child with developmental disabilities: Management of constipation. Birmingham, AL: United Cerebral Palsy of Greater Birmingham.

Sullivan-Bolyai, S. (1986). Practical aspects of toilet training in the child with a physical disability. Issues in Comprehensive Pediatric Nursing, 9, 79-96.

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CONGENITAL HEART DISEASE

Description: Children with disabilities may have one of two types of heart disease. The first type occurs before birth and is called **congenital heart disease**. A congenital heart defect generally occurs prior to the eighth week of gestation. Factors that may result in an infant acquiring a congenital heart defect include improper prenatal care, German measles, and genetic anomalies. Children with Down's Syndrome are especially at risk for congenital heart defects. **Acquired heart disease** is less common in children. A child is most likely to develop an acquired heart disease as a result of Rhuematic Fever which may cause permanent heart damage. Hypertension (high blood pressure) is another acquired heart disease, but it is generally not seen in children. Children may also have heart murmurs which may or may not be the result of some type of heart disease.

Recommendations

- Consult with the child's parents and the heart specialist (if possible) about the type of heart disease and a description of the following:
    - what caused the heart disease (congenital or acquired),
    - safety precautions for working with the child,
    - diagnostic measures that were taken to determine the existence of the heart disease,
    - surgery the child may have had to correct the heart defect,
    - medications the child has to take for the heart disease,
    - length of hospital stay for surgery (may impact development),
    - any restrictions on physical or strenuous activities, and
    - medications required during school hours.
- Know signs and symptoms of complications that may result from the heart defect (these will be different for each type of heart disease).
- All personnel working with a student with any type of heart disease should be trained to perform any type of special care (e.g. positioning) that may be needed if symptoms of distress occur at school. Training should be done by qualified health care personnel. In addition, all school personnel who work with the student should be trained in Cardiopulmonary Resuscitation (CPR) (specific to age of child).

- Consult with the parents to design a plan for associated problems or emergencies that may occur. These may include:
    - "hypoxic spells" caused by lack of oxygen, which are "characterized by hyperventilation, increasing cyanosis, and fainting" (Baum, 1982, p. 318), and
    - any other signs of heart distress.

Documentation

- Document treatment recommendations as specified by the physician.

- Document emergency procedures as planned in conjunction with the parents and physicians.

- Document training by qualified personnel for school personnel who perform any type of specialized treatment including CPR.

- Maintain incident reports (as needed) and send to parents that include:
    - observance of any type of behavior indicative of distress, and
    - use of any type of emergency technique.

- Document the administration of medications related to heart disease (use the Authorization to Administer Medications form and the Medication Record form in Appendix D). Review the section on administering medications in Appendix A.

Precautions

- Know signs and signals of heart distress in all children who may be at risk for heart disease. These include "shortness of breath, chest pain, faintness, cyanosis, very rapid heart beat and unusual fatigue" (Baum, 1982, p.324).

- Since a majority of congenital heart defects manifest themselves within the first two years of life, it is recommended that early interventionists be especially aware of the signs and symptoms of various congenital heart defects.

- Teachers should be aware of any physical activity restrictions which may prohibit a student from competing in certain athletic events and obtaining strenuous jobs.

Recommended Readings

Baum, D. (1982). Heart disease in children. In E. E. Bleck & D. A. Nagel (Eds.), Physically handicapped children: A medical atlas for teachers (2nd ed.) (pp. 313-324). New York: Grune & Stratton.

Bricker, J. T., & McNamara, D. G. (1983). Heart disorders. In J. Umbreit (Ed.), Physical disabilities and health impairments: An introduction (pp.222-232). New York: Macmillan Publishing Co.

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FEEDING DISORDERS

Description: Some students with motor disabilities (e.g. cerebral palsy) and many students with severe/profound mental disabilities have significant feeding problems. These may include poor lip closure, tongue thrust, tonic bite reflex, poor chewing, a passive swallow, insufficient gag reflex, poor dental health, and others.

Recommendations

- Proper positioning is a key factor in minimizing feeding problems as well as facilitating digestion. Overall body positioning includes positioning the students body in alignment and facilitating symmetry in both sides of the body. Use supports when needed to maintain the student's trunk and head upright and in midline (not leaning to the side or forward). The student's arms and hands are placed in a midline position (together and to the center of the body) and are supported by a lap tray or table surface. The student's feet are well supported on the wheelchair foot rests, on the floor, or by placing a bolster or box under the student's feet. Consult with occupational and physical therapists for specific recommendations about positioning and related equipment for individual students.
- Special feeding techniques or utensils may be required for some students. These may include techniques such as oral stimulation activities, jaw control, placement of food and liquids in the mouth, special cups and utensils, and others. Work closely with occupational therapists and speech therapists who have special training in prespeech and feeding techniques to learn and use appropriate feeding techniques for individual students.
- Obtain input from occupational therapists and speech therapists who have special training in prespeech and feeding techniques to vary and broaden students' abilities to consume foods of various temperatures and textures. Students who continue to eat pureed foods without consideration of systematically increasing food textures will not learn to handle (eat/drink) a variety of types of foods.
- Students with poor chewing or swallowing abilities may need foods blended in a food processor. Blend each food individually so that students are exposed to different tastes, smells, and textures. Do not blend all the students food together.
- General feeding guidelines include proper positioning of the head/neck, provision of a small amount of food on the spoon and/or cut food in small bites, and provision of liquids in small sips, making sure that the student receives adequate fluid intake throughout the day.

- Know signs and symptoms of distress while feeding:
  - change in facial expressions (e.g. look of anxiety or stress on student's face, facial color changes, perspiration on face),
  - excessive increase in muscle tone or stiffening of the student's limbs or whole body (spasticity),
  - excessive movements of arms and legs,
  - nasal flaring or increased rate of respiration,
  - frequent coughing and/or choking while eating,
  - turning head away from food offered, and
  - excessive fatigue.

- Feeding problems require a team approach for assessment and instructional programming. Team members may include occupational therapist, speech therapist, nutritionist, physician, nurse, educator, and physical therapist. School psychologists and behavior specialists may be needed for some students.

- To evaluate the possibility of feeding disorders, refer parents to their family physician. A medically prescribed test called a videofluroscopy can be conducted to determine the presence or absence of a swallowing disorder.

- Obtain information regarding food types and textures, solids vs. liquids, amount of food and liquids for mealtimes and snacks during the school day, rate of eating/drinking, and foods to avoid due to allergies or risk of choking.

- Obtain training in first aid for choking and CPR from certified instructor.

- Obtain training from qualified therapists to perform special oral motor and feeding techniques.

Documentation

- Obtain a written description of correct positioning for feeding (from physical or occupational therapists) and all special oral motor and feeding techniques and/or special equipment used during feeding (from an occupational therapist or a speech therapist who has had training in feeding).

- Document recommendations from the student's physician and parents regarding nutritional requirements, amount and rate of feeding, and foods to avoid.

- Use Feeding/Eating Record in Appendix D.

Precautions

- Avoid foods such as hard candy, nuts, and other foods that break up into small pieces and may be hard to handle and cause choking (whole kernel corn, raw vegetables such as carrots, popcorn, hard cookies, etc.).
- When cutting foods, dice or cut lengthwise (i.e. hot dog weiner).
- Obtain training in first aid for choking and CPR in case of emergency.
- Wash hands before and after feeding students.
- Use disposable napkins for clean ups or use one wash cloth for each student.
- Feed one student at a time to prevent the spread of communicable diseases (see Appendix G).
- Wear vinyl or latex gloves when feeding students **with known highly contagious conditions** (see Appendix H) or if you have an open wound or sore on your hands. If gloves are required, wear a different set of gloves for each student to prevent the spread of known communicable diseases.

Recommended Readings & Resources

Crump, M. (Ed.) (1987). Nutrition and feeding of the handicapped child. San Diego: College-Hill Press.

Morris, S. E., Kein, M. D. (1987). Pre-feeding skills: A comprehensive resource for feeding development. Tucson, AZ: Communication Skill Builders.

Alexander, R. (1991). Prespeech and feeding. In J. L. Bigge (Ed.), Teaching individuals with physical and multiple disabilities (3rd ed.) (pp. 175-198). New York: Macmillan Publishing Co.

United Cerebral Palsy (see Appendix J)

NUTRITION

Description: Students with certain medical conditions and/or feeding disorders may not receive adequate nutritional intake. This includes students who have either inadequate or excessive intake.

Recommendations

- Know signs and symptoms of poor nutrition including:
  - excessively underweight or overweight,
  - poor condition of skin such as no elasticity, presence of open sores, changes in skin color, dry or itchy skin, swelling of hands or feet,
  - poor condition of hair such as dry hair, dull hair, loss of hair,
  - cracked or peeling lips or corners of the mouth,
  - coating of the tongue, presence of cracks in the tongue,
  - abdominal distention (swollen or protruding),
  - poor muscle tone or muscle weakness,
  - poor dental hygiene, bleeding or swollen gums, dental cavities or decay,
  - lack of facial expression, and
  - irritability and other behavioral signs/changes.
- Know elements of balanced diet and basic nutritional requirements. The daily requirements for children include 3 milk servings, 2 meat or protein servings, 4 vegetable and fruit servings, and 4 grain or bread servings.
- Be aware of socioeconomic and cultural differences that influence students' dietary intake.
- If over or under nourishment is suspected, seek consultation from a nurse, nutritionist, or physician. These persons can obtain a dietary history from the family and determine if nutritional intervention is needed.
- Monitor students dietary intake and follow recommendations from health care personnel regarding nutritional needs and/or supplements.
- Measure, record, and monitor weight and height/length. A health care worker can assist in interpreting these data to determine if problems exist and recommend referral to the physician and/or nutritionist if needed.

Documentation

- Maintain daily record of student's dietary intake. Use or modify and use the Eating/Feeding Record in Appendix D.
- Obtain written instructions from the child's physician or nurse regarding special dietary concerns including:
  - amounts and schedule of dietary supplements, and
  - record of weight and height/length recorded as part of student's permanent record.

Recommended Readings & Resources

Crump, M. (Ed.) (1987). Nutrition and feeding of the handicapped child. San Diego: College-Hill Press.

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 5: Nutrition Monitoring and Supplementation)

Shaddix, T. (1986). Nutritional care for the child with developmental disabilities: Management of constipation. Birmingham, AL: United Cerebral Palsy of Greater Birmingham.

National Center for Nutrition and Dietetics (see Appendix J)

ORTHOTIC CARE

Description: Orthoses, commonly referred to as braces or splints, are devices used to prevent joint contractures and bone deformities and also to facilitate proper joint alignment to assist in weight bearing and walking. Braces are made of either metal or plastic that is molded to fit the child. There is a wide variety of braces from those that support the child from the chest to the feet (e.g. reciprocating gait orthosis) to those that support only the ankle and foot (e.g. ankle-foot orthoses). Braces may also be used to prevent joint contractures in the upper extremities (arms and hands).

Recommendations

- Consult with the student's orthopedic specialist, physical therapist or occupational therapist (hand splints), and parents about the type of orthotic device and a complete description of the following:
    - why the orthotic device is needed,
    - how to place the brace on the child,
    - how long each day the child is to wear the brace,
    - activity restrictions while the brace is being worn,
    - movement patterns that are being promoted while the brace is worn, and
    - other treatment techniques used to prevent the orthopedic problem.
- Obtain training from a qualified physical therapist to put the braces on the child. All school personnel working with the student should receive this training.
- Know signs and symptoms of complications that might arise and make plans in advance to deal with these.
- Consult with parents to design a plan for complications that may arise as result of wearing orthotic devices. These may include:
    - metal, plastic, or strapping that maintains contact with skin, and
    - any skin irritation resulting from new or improperly fitting braces.

Documentation

- Document treatment recommendations as specified by the physician and/or physical therapist with parental consent.
- Document procedures for dealing with complications as planned in conjunction with the parents.

- Document training by qualified personnel (e.g. physical therapist) for school personnel who monitor the fit and function of othotic devices.

- Document that periodic checks have been made to assure that the orthotic device fits properly (by physical therapist).

- Maintain weekly treatment record (sent to parents) including:

  - length of time orthotic device was worn each day,
  - movement pattens that are being encouraged during time orthotic device is being worn,
  - signs of skin irritation, and
  - recommendations by physical therapist to have braces changed for appropriate fit.

Precautions

- Improperly placing an orthotic device on a student can cause orthopedic problems including bone fractures.

- Orthotic devices that fit improperly **can** cause serious skin irritation. Do not disregard a student's behavioral signs of discomfort or unwillingness to wear the device as simply an intolerance for the device.

- Pressure points (red marks) that do not disappear in 20 minutes are reported to the parents and physical or occupational therapist (hand/arm splints). This condition can lead to pressure sores.

- Students should not wear orthotic devices for extended periods of time upon initial receipt of the device. Likewise, the length of time the student wears the device should be reduced following extend periods of time when the device was not worn (e.g. vacation).

- Training should not exclude other tasks involved in the use of orthotic devices including ambulation and movement transitions.

Recommended Reading

Lough, L. K. (1990). Bracing. In J. A. Blackmon (Ed.), Medical aspects of developmentally disabilities in children birth to three (2nd ed.) (pp. 25-44). Rockville, MD: Aspen Publishers.

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PROSTHETIC CARE

Description: A prosthesis replaces a missing body part. The information contained in this section refers to artificial limbs which replace the function of missing arms and/or legs. Prostheses are custom molded for the individual and are held on with straps or a harness.

Recommendations

- Consult with the student's physician, prosthetist, physical or occupational therapist, and parents to obtain a complete description of the following:
    - type of prosthesis and how it operates,
    - type of training the child needs to become functional with the prosthesis and who will do the training,
    - abilities of student with prosthesis,
    - potential dangers to other students that could be caused by prosthesis,
    - the schedule for wearing the prosthesis,
    - indications that the prosthesis is not functioning properly,
    - activities that should be avoided while the child is wearing the prosthesis,
    - assistance the child needs while wearing the prosthesis, and
    - how to apply the prosthesis.
- Know the signs and symptoms that indicate that the prosthesis does not fit properly.
- Design a plan for explaining to other children in the classroom about the prosthesis.

Documentation

- Record as needed any signs of skin irritation including bruising, rashes, or abrasions that result from wearing the prosthesis and report these to the parents and appropriate ancillary personnel (occupational therapist for upper extremities or physical therapist for lower extremities).

Precautions

- Poor hygiene can cause skin irritations. Teachers should be aware of such situations and alert parents if they notice this.
- Be sensitive to the emotional needs of the student wearing the prosthesis. Avoid teasing by other students by explaining or having the child explain the device.
- Consider the physical education needs of the student. Students wearing artificial limbs are encouraged to participate in physical education as much as possible, but may require adapted physical education and/or consultation from

an adapted physical educator.

- Consideration should be given to the fact that the child with absent limbs may perspire more than a typical child. Therefore, their underclothing may need to be changed more frequently. Also, children with absent limbs may run extremely high temperatures during minor infections such as a cold.

Recommended Readings

Frederick, J., & Flether, D. (1985). Facilitating children's adjustment to orthotic and prosthetic appliances. Teaching Exceptional Children, 17 (3), 228-230.

Setoguchi, Y. (1982). Amputations in children. In E. E. Bleck & D. A. Nagel (Eds.), Physically handicapped children: A medical atlas for teachers (2nd ed.) (pp. 17-26). New York: Grune & Stratton, Inc.

Brooks, M. (1983). Limb deficiences. In J. Umbreit (Ed.), Physical disabilities and health impairments: An introduction (pp. 93-99). New York: Macmillan Publishing Co.

SHUNT MONITORING

Description: A shunt is a plastic tube placed into the ventricle of the brain to drain excess cerebrospinal fluid. Children with an excess of cerebrospinal fluid are said to be hydrocephalic (enlarged head due to excess fluid). The shunt leads from the brain to a particular cavity of the body where the excess fluid is received and processes or eliminated from the body. The shunt may drain the cerebrospinal fluid into either the heart chamber or the abdominal cavity (most common, ventricular peritoneal).

Recommendations

- Consult with the student's physician and/or neurologist and parents about the type of shunt and a complete description including:
    - child's typical behavior and how it may differ if the shunt is malfunctioning,
    - knowledge of signs and symptoms of malfunctioning shunt, and
    - when the shunt was inserted and any warning signs that may result during the first weeks following insertion.

- Know signs and symptoms of complications that might arise and make plans in advance to deal with these.

- Consult with parents to design a plan for emergencies that may result from the shunt. These may include:
    - behavioral symptoms including irritability, restlessness, personality change, lethargy, drowsiness, inability to follow simple commands, and decreased orientation to time and place; and
    - physical symptoms including headache, nausea, vomiting, double or blurred vision, seizures, soft spot becomes full, and changes in reaction to light

Documentation

- Document emergency procedures as planned in conjunction with parents.

- Maintain weekly observation records (copy sent to parents) that include:
    - any changes in behavior or physical symptoms as described above,
    - level of activity, and
    - response to and awareness of environment.

- Document occurance of seizures and any other emergencies that require medical attention at school.

Precautions

- Physical and behavioral symptoms of shunt malfunction are reported to the child's parents immediately. Any rapid increase in pressure in the brain can result in serious complications and death.
- If school health care workers are not available, the Emergency Medical Team (EMT) should be notified in the event of an emergency situation. The student's parents should be also be notified immediately if the student is showing signs of shunt malfunction.

Recommended Readings

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 9: Monitoring a Shunt)

Wolraich, M. L. (1990). Hydrocephalus. In J. A. Blackmon (Ed.), Medical aspects of developmentally disabilities in children birth to three (2nd ed.) (pp. 175-180). Rockville, MD: Aspen Publishers.

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SKIN CARE

Description: Children who have limited movement or mobility, may require special skin care to prevent the development of skin breakdown and pressure sores.

Recommendations

- Know signs and symptoms of developing skin problems including:
  - pressure points (red marks) that do not disappear in 20 minutes can lead to pressure sores and are reported to the parents, and
  - signs of skin irritation including swelling, redness, tenderness, bruising, rashes, abrasion, or other signs of problems.

- Apply topical treatments or dressing changes as specified by physician. Unlicensed school personnel may change simple nonsterile dressings. Complex dressings requiring a sterile technique should be performed by a qualified licensed health care professional.

- Promote practices that prevent skin problems including keeping the skin clean and dry, proper nutrition and fluid intake, frequent position changes, and activities to promote circulation.

Documentation

- Document treatments and recommendations as specified by the physician with parental consent (use the Authorization for Treatment form in Appendix D).

- Document topical medications and treatment applications when required (use the Authorization to Administer Medication form and the Medication Administration Record in Appendix D).

- Record as needed any signs of skin irritation including swelling, redness, tenderness, bruising, rashes, abrasion, or other signs of problems and report these to the parents.

Precautions

- Wear vinyl or latex gloves if applying topical treatments, changing dressings, or dealing with open sores or injuries.

Recommended Reading

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). Health care for students with disabilities: An illustrated medical guide for the classroom. Baltimore, MD: Paul H. Brookes. (see Chapter 4: Skin Care)

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APPENDIX C

Developing Appropriate Individual Education Programs for Students with Special Health Care Needs

DEVELOPING APPROPRIATE INDIVIDUAL EDUCATION PROGRAMS FOR STUDENTS WITH SPECIAL HEALTH CARE NEEDS

Historically, Individual Education Programs (IEPs) for students with complex health care needs have often contained objectives that indicated what would be done to the student and not what the student will learn. For example, the IEP may have contained **inappropriate or noninstructional objectives** such as:

> The student will be fed three times a day with a gastro-intestinal feeding tube.

or

> The student will be positioned in 5 different positions throughout the school day.

Objectives such as these can be referred to as "staff directives" as opposed to student objectives. The content of "objectives" such as these refers to related services the students requires during the school day. As with other related services, such as physical therapy, procedures requiring support from school health services are included in the student's IEP. The IEP also contains information about how often the related service will be provided. With related services such as physical therapy, the skills the physical therapist wants included in the IEP will be written on the document in the form of instructional objectives. However, when the related service is school health services, the process is somewhat different in that health procedures are not in and of themselves skills the student will learn.

Thus, it is suggested that teachers include information about health care procedures on a separate page of the IEP. Information that is provided on this page includes a) a description of the required procedures, b) the person who is primarily responsible for carrying out the procedures, c) the back-up person(s) who will carry out the procedures in the absence of the primary person, and d) when the procedures will be initiated, reviewed, and end. An example of how this might look is shown below:

REQUIRED PROCEDURE DATE	PERSON(S)	DATE	
	RESPONSIBLE	BEGIN	END
The student will receive medication three times per day each day he is at school.	Teacher (Primary) Teacher Assistant (back-up)	Aug 1991	June 1992

Once the procedure has been included in the IEP, a program plan is developed for each procedure. The plan includes the student's name, name and description of procedure, the primary and back-up person(s) responsible for carrying out the procedure, the rationale for why the procedure must be conducted, the steps required to perform the procedure as outlined by a qualified medical personnel (e.g. physician, nurse), materials needed to perform the procedure, and documentation required. See Appendix E for Program Plan and Training Form and Appendix D for School Health Care Services Record form.

The teacher will also need to write instructional objectives related to instruction that will occur during the health care routine. The reader is referred to Hudson and Leatherby (1991) for a detailed summary of how to write instructional objectives within activities and/or routines. Health care procedures are routines that are required on a daily basis. Again, they are not skills for the student to learn. However, health care routines may take a significant portion of the student's day, and are viewed as opportunities for instruction as would any other activity. Health care routines can be utilized for instruction by embedding instruction in basic skills (e.g. communication, motor, sensory) into these routines. Following the format for writing instructional objectives by Hudson and Leatherby (1991), an objective which includes the health care procedure of gastro-intestinal tube feeding might look like this:

When involved in an activity (described below) and given a verbal cue to "reach for ________" and when the item is placed 2-4" in front of the student, he will extend his right forearm from the elbow to make contact with the item within 15 seconds, 4 of 5 opportunities (for 3 consecutive days).

Examples of activities in which the student will practice reaching are:

1. reaching for switch to operate appliance during snack
2. reaching for switch to operate video game during leisure time
3. reaching for coat hook to hang up coat during arrival time
4. reaching for switch to operate electric can opener to open can of formula for G-tube feeding.
5. reaching for the supplies during G-tube feeding to assist with feeding during lunch

The health care routine can then be added to the activity matrix to as an activity occurring during the student's daily schedule (see Hudson & Leatherby, 1991).

Although, it has been stated that health care procedures are not in and of themselves instructional objectives for the child, there is one exception to that fact. For certain procedures, it is possible, that some students might eventually perform them independently. Catheterization is one example. Students with adequate cognitive and physical abilities can be taught to catheterize themselves, and are encouraged to do so. With procedures such as these, instructional objectives are written to reflect independence as the criterion. An example is shown below:

When given the materials needed for catheterization and given the verbal command to do so, the student will catheterize himself by independently performing 100% of the steps of catheterization 2 of 2 times per day each day of the school year.

Self catheterization falls within the independent living domain and certainly would be considered a functional skill to teach. For programming planning purposes, the teacher develops a task analysis of the steps required to perform catheterization and identifies an appropriate instructional strategy for teaching the procedure. Making both of the these decisions requires input from the student's physician or school nurse. The Program Plan and Training Form may be used or adapted for the purpose of direct instruction of the student.

As with other related services, health care procedures need to be addressed on the IEP. Teachers and other members of the Admissions and Release Committee should remember the following when including these procedures:

1. If the procedure has to be performed by an adult, it should not be included as an instructional objective for the child. (see #2)
2. Administering health care procedures is considered a related service and is included on the IEP, but not written as an instructional objective. (see #1)
3. Health care procedures are considered routines in which instruction can occur. Basic skills taught within these routines are included on the IEP noting that the routine provides an additional context for instruction of these skills.
4. Some students may be able to independently perform certain health care procedures themselves. Systematic instruction is planned with input from appropriate medical personnel.

APPENDIX D

Sample Letters and Forms for Health Related Procedures and Concerns

Authorization to Give Medication

Medication Administration Record

Authorization for Treatment

Special Health Care Services Record

Seizure Record

Feeding/Eating Record

Positioning Requirements Form

SUGGESTED USE OF SAMPLE LETTERS AND FORMS

Authorization To Give Medication (sample letter and form): Use to obtain permission from parents/guardian if medication must be administered by school personnel. Adapt cover letter for district use and put on district/school letterhead. Use or adapt form on bottom half of page and put on school district letterhead. Must be completed/on file before any medications can be given by school personnel. See Appendix A for additional information.

Medication Administration Record (sample form): Use to document administration of medication by school personnel. The top portion of the form (matrix/boxes) is used to document each medication that is given at school including the name of the medication, dosage, time(s) to be given, pharmacy, prescription number (shown on label), and other comments or possible (and known) side effects. The bottom portion of the form is used to document each any medication is given including the date, time, medication type and dosage, the initials of the person who administered the medication, and any comments or problems and to whom these were reported. Use one form for each student. See Appendix A for additional information.

Authorization For Treatment (sample letter and form): Use to obtain permission from parents/guardian to provide treatment/perform health-related procedures during the school day. This is required whether the procedure is done by a licensed health care provider (e.g. nurse) or by a trained teacher or teacher assistant. Use this form for all the procedures described in Appendix A unless a specific form is described in this section for the procedure.

Special Health Care Services Record (sample form): Use this form to record when health-related procedures are performed by school personnel (both licensed health care staff or teaching staff). Complete the top portion then use the bottom portion to record each time the procedure is performed. Record the date, time(s) of day the procedure was done, the initials of the person who performed it (must be the trained person(s) listed on top portion), and any comments or problems that occurred and to whom these were reported. See Appendix A for information on specific procedures. Use one form for each student and each different procedure.

Seizure Record (sample form): Use this form to record seizures. Complete the informational section at the top and obtain the physician's signature. Based on information from the parent and/or physician, complete the baseline section with information regarding student's typical seizure behavior. Record the date; start/stop time; the initials of the person who observed the seizure and completed the forms; behaviors student exhibited based on the given checklist and any comments including intervention or problems and to whom these were reported. Use one form for each student. See Appendix A for additional information on seizures.

Feeding/Eating Record (sample form): Use this form to record feeding/eating recommendations or interventions used. Complete the top portion of the form for the student and use the bottom portion to record feeding/eating interventions and/or problems. Record the date, initials of the person trained in feeding the student/using special feeding procedures; and any comments or problems that occurred and to whom these were reported. Use one form for each student. See Appendix B for additional information on feeding/eating.

Positioning Requirements (sample form): Use to document recommendations about positioning provided by a licensed physical and/or occupational therapist. The team leader (usually the special education teacher) should complete with the therapist and share with the parents. Complete one form for each student. See Appendix B for more information on positioning.

AUTHORIZATION TO GIVE MEDICATION*

Dear Parent or Guardian:

In order for school personnel to administer any type of medicine to your child at school, we must have on file a signed affidavit giving your permission for us to do so. The medicine should be sent to school with complete instructions and in its original container which must have the prescription label attached. Please be sure to complete all information that is listed on the form below before returning it to school.

Sincerely,

Principal

School Nurse (if applicable)

Date ____________________

I hereby request school personnel of ______________ Public School to give medicine to my child, ____________________ . This medicine has been prescribed for my child by Dr. ____________ whose address is ______________________________________ .

These instructions should be followed in giving my child this medicine.

1. Type of medicine: ______________________________
2. Dosage: ______________________________
3. Time of day the medication is to be given at school: ____________________
4. Reason medication is to be given: ______________________________
5. Reactions or side effects: Please list potential reactions the child might have to medication:
   ____
   ____
6. Physician's telephone number: ______________________________
7. Physician's signature: ______________________________
8. Parent's telephone number: Home __________ Work __________ Emergency __________
   I give my permission for ______________ School System to administer the above medication for my child during school.

   ____
   Signature of Parent or Guardian

*NOTE: Use school letterhead. Obtain information for each medication. Adapted from *School Health Services Manual* (1990), Kentucky Department of Education.

MEDICATION ADMINISTRATION RECORD

Student Name ______________________________ Class ______________________________

School Personnel Trained to Perform Procedure ______________________________

Medication	Dosage	Time(s)	Pharmacy	Prescription #	Comments/Side Effects

Date	Time	Medication & Dosage	Initials	Comments or Problems (Reported to Whom)

Additional Comments:

A = Absent from School
C = Change in Dosage

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AUTHORIZATION FOR TREATMENT*

Dear Parent(s) and/or Guardian:

If your child requires a specific health related tratment or procedure done at school, we need to have the following information, as well as signed permission from you and your child's physician. The purpose of this is to make sure your child gets the required treatment or procedure as ordered.

Student's name: ____

Duration of this form: __________ school year or until the treatment is changed.

Describe the treatment procedure in detail and include any specific instructions:

____

____

____

Times to be administered: ____

During the school hours of _______ and _______ it is my understanding that the school nurse and/or trained school personnel will administer the prescribed treatment or procedure according to the above instruction of the physician.

Sincerely,

Principal

School Nurse (if applicable)

- -

Authorization Signatures

______________________ ________ ______________________ ________

Parent Date Physician Date

____

Physician's Address City/State Zip Telephone Number

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*NOTE: Use school letterhead.
Adapted from Kenton County Schools
Independence, Kentucky

SPECIAL HEALTH CARE SERVICES RECORD*

Student ______________________________ School/Class ____________

Procedure ____

School Personnel Trained to Perform Procedure ______________________

Special Considerations _____________________________________

____

Signs and Symptoms of Problems _______________________________

Note: Gloves are required. Proper Disposal of Waste: ____________________

Date	Time(s)	Initials	Comments/Problems (Reported to Whom)

*Note: Refer to Program Plan & Training Form (see Appendix E) for instruction per procedure.

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Jefferson County Public Schools
PHYSICIAN'S AUTHORIZATION/SEIZURE RECORD FORM

Please return to:____________________

Student's Name:____________________
Parent Signature____________________
Date____________________

Physician's Signature __________ Date _____ TYPE OF SEIZURE:__________ **PHYSICIAN: Please specify by commenting on each characteristic of typical seizure**	SCHOOL PERSONNEL; Please check observed characteristics of seizure activity

Medication:______ Dosage:______ Times:______				Date:											
		Baseline		Stop/Start Times											
		Yes	No	School Personnel Initials											
DURATION	Specify seconds, minutes, etc.														
AURA	Conditions or behaviors that usually precede the seizures:														
EXTREMITIES	Rt. Arm Limp (L), Jerking (J) Extended (E), Flexed (F)														
	Lt. Arm Limp (L), Jerking (J) Extended (E), Flexed (F)														
	Rt. Leg Limp (L), Jerking (J) Extended (E), Flexed (F)														
	Lt. Leg Limp (L), Jerking (J) Extended (E), Flexed (F)														
EYES	Rolled Back														
	Staring Straight Ahead														
	Twitching Back and Forth														
	Looking to Left														
	Looking to Right														
MOUTH	Drawn to the Left														
	Drawn to the Right														
	Bites Tongue														
	Teeth Clenched														
BREATHING	Noisy Breathing														
	Heavy Breathing														
	Change in Skin Color														
	Not Breathing														
OTHER	Incontinent of Urine														
	Incontinent of Stool														
	Vomiting														

COMMENTS	Description of seizures including movements, change in behavior or skin color. (Attach additional comments as needed).	
INTERVENTION	If symptoms persist after physician's recommendations have been followed: 1. Notify parents 2. Call 911, using Emergency Information Appendix p. 89	If breathing stops: 1. CPR certified staff administers CPR 2. Call 911, using Emergency Information (Appendix p. 89) 3. Notify parents.

BEST COPY AVAILABLE

FEEDING/EATING RECORD

Student ______________________ School/Class ______________

School Personnel Trained in Special Oral Motor or Feeding Techniques ______________

Feeding/Oral Motor Needs/Interventions ______________________

Positioning for Feeding/Eating: ______________________

Feeding Equipment: ______________________

Food Types/Amounts/Textures: ______________________

Recommended/Trained by: ______________________

Precautions: ______________________

Date	Initials	Comments or Problems (Reported to Whom)

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POSITIONING REQUIREMENTS*

Student ____________ School/Class ________________ Therapist ____________ Date ________

Positioning Options: Complete all that apply. Personnel Trained in Positioning ________________

Position	Purpose	Equipment	Proper Use & Precautions	Amount of Time	Activities
Prone					
Supine					
Sidelying					
Sitting					
Standing					

Other Positioning Recommendations: ____

____

Additional Comments: ____

____

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*NOTE: Therapist trains personnel and attaches description (picture) of each position.

APPENDIX E

Sample Program Plan/Training Form

SUGGESTED USE OF SAMPLE PROGRAM PLAN/TRAINING FORM

Purpose: Use this form as both a program plan form (child and procedure specific) and a training form when training unlicensed or untrained school personnel. The form is used when training school personnel to perform the health-related procedures described in Appendix A. The form should also be used when training school personnel to perform any other procedures that unless performed correctly might cause harm to the student. (e.g. other health-related concerns such as positioning, lifting, transfers, special oral motor and feeding techniques described in Appendix B.) All training or unlicensed school personnel must be provided by appropriate licensed health care personnel or related services personnel (e.g. nurse, physical therapist, occupational therapist, speech-language pathologist, etc.)

Instruction: In the left column, list the 1) materials and terms involved in the procedure (e.g. identify the g-tube, and type of formula, etc.) 2) steps involved in the procedure (task analysis), and 3) other critical information related to performing the procedure (e.g. amount of formula, length of time or speed to give, signs or symptoms of problems, emergency procedures). If the procedure is one of those described in Appendix A, these "steps" must be approved by the student's parents and physician (see space for physician's signature on top portion of form, parents signature on page two). In some cases the physician may complete the form. However in most cases, the designated licensed health care provider completes the form with students parents/guardian and sends it to the physician for approval and authorizing signature. Remember, you must also have a completed Authorization for Treatment Form signed by the student's parents/guardian (see Appendix D).

The grid or matrix to the right of the "steps" column is used by the trainer to record if the trainee (unlicensed school personnel) can perform each "step" by recording "+" to indicate that the step was done incorrectly. The trainee must "pass" by performing 100% of the steps correctly over three training sessions. Then the trainee can be allowed to perform the procedure. However, their performance is monitored periodically by the designated licensed health provider or trainer. The signature lines for the instructor on page two of the form should be completed by the trainer to document that raining has occurred. Review (as many times as needed) the section entitled "Training Unlicensed School Personnel to Perform Special Health Care Procedures" contained in the from portion of this document.

PROGRAM PLAN & TRAINING FORM*

Student ______________________________ School/Class ______________

School Personnel Trained to Perform Procedure ______________________________

Consider this a prescription for the above named student's ______________________________ (procedure)

Perform the procedure as outlined in this checklist.

____
Physician's Signature Date

	Dates of Training/Monitoring (T = Training, M = Monitoring)													
Information & Procedure Steps														

Dates of Training/Monitoring (T = Training, M = Monitoring)

Special Considerations (e.g., positioning) ____________________

Signs and Symptoms of Problems ____________________

(Code each step "+" or "-") (Date Trained) (Recommended Recheck)

Instructor ____________ Date ____________ Date ____________

Instructor ____________ Date ____________ Date ____________

Instructor ____________ Date ____________ Date ____________

Checklist content approved by:

Parent Signature ____________ Date ____________

*Note: Complete a form for each person trained. Serves as Program Plan.

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Adapted from: Ventilator-Assisted Care Program
Children's Hospital, New Orleans, LA.

APPENDIX F

Related School Health Information

Recommended School Health Policies

Health Requirements for School Admittance

RECOMMENDED SCHOOL HEALTH POLICIES

The focus of this document has been on providing health care services to students with special health care needs. However, school health services exist for all students. Teachers should make themselves aware of these services in order to assure that a healthy school environment is maintained. The Kentucky Department of Education has developed a manual outlining guidelines and regulations for health services in schools. Below is a summary of some of those guidelines and regulations as well as some additional suggestions for a healthy school environment. Teachers should acquire this manual entitled *School Health Services Manual* for complete information on this topic. If a manual is not available at your school, one can be attained from the Division of School Health Services, Kentucky Department of Education.

School Health Coordinator

Each school system is required to employ a school health coordinator to work with school personnel to coordinate health services. Some of the job responsibilities of the school health coordinator include a) coordination of health screening programs, b) supervision of first aid, and c) follow-up of a student after a prolonged illness, injury, or hospitalization. Teachers should be aware of who the school health coordinator is in their school district and become familiar with all the services they provide.

First Aid Policy

Schools are required to take measures to prepare for medical emergencies that occur at school. Some of these emergencies include treatment for abrasions, insect stings, cessation of breathing, fractures, frost bite, and nose bleeds. In order to treat such emergencies schools are required to have the following: a) a first aid room or suite to deal with such emergencies, b) a minimum of two (2) persons in the school who are certified in first aid training, and c) a first aid kit with supplies for at least 50 children. Having someone at the school who is certified in CPR is also highly recommended. The *School Health Services Manual* has information on recommended supplies for a first aid kit as well as information on treating medical emergencies such as those listed above. Teachers should make themselves aware of where the first aid kit is located and who in the school is certified in first aid and/or CPR. It is also recommended that teachers always take a first aid kit on field trips and during any community based instruction activities. The *School Health Services Manual* also recommends that schools post emergency numbers such as ambulance service and police departments.

Health Screenings

The *School Health Services Manual* states that the purpose of health screening .... "is to detect previously undiagnosed health problems that may, by health intervention, be more readily corrected" (p. 16). Below is a list of health screenings that occur at school along with a summary of when these screenings should occur.

Vision Screening: Vision screening is recommended for students in kindergarten, first, third, and fifth grades and for students who presently have diagnosed visual difficulties. In addition, teachers may recommend that a student's vision be screened in any grade if they feel the student is having difficulty.

Hearing Screening: A student's hearing is screened in kindergarten, first, third, and fifth grades. Other students who should have their hearing screened on a regular basis include students in special education classes, students with known hearing problems, and students who have chronic ear infections. In addition, transfer students should have their hearing screened.

Scoliosis Screening: The purpose of scoliosis screening is to determine if a student has a spinal abnormality which manifests itself in a curvature of the spine. The Kentucky Department of Education recommends that scoliosis screening occur during sixth and eighth grades and if possible during the ninth grade.

Head Lice Screening: Screening for head lice is conducted on an "as needed" basis when a break-out occurs.

Height and Weight Screening: The Kentucky Department of Education recommends that height and weight be measured during each of the elementary grades and at least once during both middle and high school years.

Dental Health Education and Flouride Mouthrinse Program

While screening for tooth decay is not a requirement of school systems, the Department of Education recommends that teachers educate students about healthy dental habits to prevent tooth decay. In addition, it is recommended that schools implement a weekly flouride mouthrinse program. Such a program can be implemented through the health department at no charge to the school. If schools have not implemented such a program, it is recommended that teachers approach their principal about the possibility of doing so.

HEALTH REQUIREMENTS FOR SCHOOL ADMITTANCE

Children entering school in Kentucky for the first time (grades K - 12) are required to present evidence of medical intervention not conducted by the school.

Medical Examinations

According to the *Kentucky School Health Services Manual* :

> "All students must have a medical examination within six months prior to or 30 days after initial admission to school. The examination must be reported on the prescribed Kentucky Department of Education (KDE) form and should include a medical history, assessment of growth and development and general appearance, physical assessment including hearing and vision screening, and any recommendations to the school regarding health problems that may require special attention in the classroom or during P.E. activities. Children transferring into a district must comply with the above requirements." (p. 43)

Tuberculosis Testing

All children entering school in Kentucky for the first time must have a tuberculosis test. Children transferring from one school to another in the state are not required to have the test retaken, however, students transferring from other states must have be tested in Kentucky. A student can attend school for 30 days before showing proof that they have been tested. After that time they may be expelled if proof is not provided. Proof of the tuberculosis test is generally shown on the medical examination form or is documented on "Tuberculin Test Certificate".

Immunization Certificate

All children entering Kentucky schools for the first time are required to present an immunization certificate from a physician on the first day of classes, demonstrating that immunizations are up to date. It is recommended that immunization certificates be monitored bi-annually to assure that they have not expired. Page 103 of the *School Health Services Manual* outlines the exclusion policy for students not presenting a valid immunization certificate. There are exemptions for not having a valid immunization certificate and not having a tuberculosis test. These include medical exemptions and religious exemptions and are discussed in detail on page 102 of the manual.

School Health Records

In addition to the medical examination form and the immunization form, there are additional forms related to a student's health that are kept in the student's cumulative folder.

Cumulative Health Record Form: This form is used to record results of a) all health screenings, b) record weight and height, c) provide evidence of immunization certificate, and d) record health care given at school.

Emergency Information Form: All children enrolled in school should have an emergency information form completed which provides information to school personnel regarding who should be contacted in case of an emergency, including who should be contacted if the parents can not be reached. In addition, the form asks for information regarding medication and special health conditions including allergies and seizures. Often a version of the emergency information form is used to obtain permission from parents for students to take field trips. These forms should accompany the child on any out of school trips, including community-based instruction, in case there is an emergency.

Accident/Incident Form: This form is to be completed when a student is injured at school. Treatment information is included on the form, as well as a detailed summary of how the incident occurred. Accident/incident forms are kept in each student's cumulative record.

Authorization to Give Medication and Daily Log for Medication: Prior to dispensing medication to a student, permission is obtained from parents to do so. Information contained in this permission form includes a) the type of medication, b) the dosage, c) time of day for dosage, d) reason for medication, e) side-effects, and f) physician's phone number.

A daily log for dispensing medication is required. Information included in the log includes student's name, type of medication, dosages, and times it was given. A sample of both the Authorization to Give Medication Form and the Medication Administration Record Form are contained in Appendix D.

General Guidelines

In addition to the required health services mentioned above, there are additional guidelines school personnel should follow in order to assure that a healthy school environment exists. These include:

1. Develop a parent handbook outlining the school's policies in regard to health care. For example, parents should know the policy for leaving sick students at school and what the expulsion policy is for students with head lice. Information such as this will prevent misunderstandings from parents who may think school personnel are merely trying to prevent their child from attending school.

2. Make parents aware when there is an outbreak of a particular illness. For example, if there is an outbreak of head lice, send a note home to all parents in the class or even in the entire school. Explain to parents how to detect the problem and how to treat it.

3. Provide training for school personnel in health related needs and include information on preventing the spread of communicable diseases (see Appendix G).

4. Make health records available to teachers. There is an abundance of valuable information in a child's cumulative health record. As children move through grades, each teacher should spent time familiarizing themselves with the health needs of their students. For example, they should know if they have students with particular allergies or students who have seizures.

5. An essential part of a healthy school environment is school sanitation. There are specific regulations regarding school sanitation (902 KAR 45:150) and teachers should be aware of these regulations. The sanitation regulations relate to, among other things, restroom facilities, lighting, and safety. These regulations are monitored twice yearly by the Cabinet for Human Resources. Teachers should do their part to assure that their students go to school in a safe, clean environment. While there are not specific regulations regarding safety within individual classrooms, teachers should consider safety factors when arranging their classroom. In situations where a student in the class or school has either a physical or sensory disability, environmental safety considerations become even more critical.

APPENDIX G

Preventing Transmission of Communicable Diseases

Daily Practices to Prevent Transmission of Communicable Diseases

Universal Precautions

DAILY PRACTICES TO PREVENT TRANSMISSION OF COMMUNICABLE DISEASES

All school personnel should be aware of practices to prevent transmission of communicable diseases. Using these practices can prevent the spread of any and all childhood diseases and illnesses in schools. School personnel should receive training in these procedures and processes should be developed to conduct periodic follow-ups to ensure that procedures are being followed, including conducting site visits and annual reviews of prevention information. This section describes information regarding hand washing, feeding/eating, diapering/toileting, cleaning, and universal precautions (references).

Hand Washing

The best way to prevent the spread of illnesses and communicable diseases is to practice frequent hand washing. Use the following method to make sure your hands are free of germs:

Use soap and running water.
Rub your hands vigorously as you wash them.
Wash all surfaces including backs of hands, wrist, between fingers, and under fingernails.
Rinse your hands well. Leave the water running.
Dry your hands with a paper towel.
Turn off the water using the paper towel instead of your bare hands.

Hand washing should be done when arriving at school in the morning, before eating, before preparing and/or serving food, after feeding students, after performing any medically related procedure, after toileting or diapering a student, after wiping a student's nose or cleaning up messes, and after toileting.

Feeding/Eating

In addition to washing hands before and after feeding a student, other precautions should be taken. All students hands should be washed before and after eating. In addition, after meals all messes should be cleaned (e.g. wiping mouth and face areas, change clothing if soiled, cleaning and wiping of chairs or wheelchairs and tables if food is present). Use disposable towels for wiping and cleaning up messes. If towels are used, use one per student and wash these immediately after use in hot water using chlorine bleach. All eating utensils should be washed immediately after use in the school's commercial dishwasher to sterilize or in hot water using chlorine bleach in conjunction with detergent.

Diapering/Toileting

When changing diapers, change diapers directly on paper towels, roll paper, or other disposable covering. Place the disposable cover on a surface that is smooth, nonabsorbent, and easily cleaned (e.g. formica, plastic, vinyl, metal, enamel, or diapering pad). The diapering area should be a out of reach of other children, separate from food preparation areas, and within easy reach of a sink not used for food preparation. When diapering or dealing with toileting accidents, use disposable cleaning materials only (e.g. towelettes, paper towels). Dispose of cleaning supplies, changing towels/paper, and soiled diapers in a plastic bag or plastic lined receptacle. Clean and disinfect the diapering area and equipment or supplies touched. If the child has to be washed completely, use running water and disinfect the sink immediately after. If soiled clothes are involved, place them in a plastic bag and send them home for laundering.

Cleaning

Be sure all facilities (e.g. tables, mats, etc.) and supplies are washed with soap and water, then disinfected with either a bleach solution (1 cup bleach per gallon of water or 1/4 cup bleach per quart) or a commercial disinfectant that kills bacteria, viruses, and parasites. Cleaning should be done daily. A spray bottle is easy to use and handy for storage. If bleach solution is used, it should be made fresh daily. Use washable teaching materials and wash these weekly using bleach solution or disinfectant. Daily washing of materials may be necessary if they are mouthed by students who have communicable diseases. Carpeted areas should be vacuumed daily.

Children who take naps should have individual mats or mattress covers and linens labeled with their own names for consistent use. These mats should be cleaned at least weekly or daily if students have communicable diseases.

UNIVERSAL PRECAUTIONS

In addition to the hygiene and cleaning practices previously described, the Centers for Disease Control (1987) and the Children's Hospital in Boston have recommended a list of universal precautions to prevent the transmission of communicable diseases. These universal precautions are recommended to be used by all persons who have contact with blood or body fluids, perform specialized health care procedures, and/or feed or toilet students. These persons are particularly at high risk for contracting communicable diseases and should follow these universal precautions:

- Utilize frequent hand washing using the method described in the previous section. This is the best prevention against the spread of infections and cannot be over emphasized.

- Wear vinyl or latex gloves when touching blood or body fluids, mucus membranes, or open skin areas. (Appropriate vinyl or latex gloves are available from any medical supply company.)

- Avoid contact with and injuries from needles or other sharp instruments that have come in contact with body fluids.

- Make sure that all needles are disposed of in appropriate sharps/infectious waste containers.

- Dispose of waste and soiled supplies or clothing in the proper manner. Flush body fluids/waste down the toilet. Place soiled clothing in a plastic bag and send home with the student. Please discuss these practices with parents and explain why they are needed in the school setting.

Specific information on precautions and waste disposal for specific health care procedures and concerns is presented in Appendices A and B.

APPENDIX H

Communicable Diseases

COMMUNICABLE DISEASES

HIV-positive (AIDS): Children who are HIV-positive should be admitted freely to all school activities. This virus is transmitted through blood, breast milk, semen, and vaginal secretions. Precautions include following hand washing recommendations previously described, and avoiding direct contact with blood. No vaccine is available. The primary means of contracting the virus is vaginal and anal intercourse with an infected partner, sharing needles for intravaneous medicine or drug use with another person infected with the virus, and obtaining a transfusion with blood that contains the virus. One case has been documented where a woman contracted the virus from her infected dentist who had an open wound on his hand and was not wearing latex gloves.

Hepatitis B Virus: Hepatitis B Virus is an inflammation of the liver and is highly contagious. The virus may be transmitted through contact with any and all body fluids including blood, urine, saliva, and other body fluids. Hepatitus B infection can become a chronic condition in some cases and the infected person becomes a carrier. A carrier does not appear ill with the disease, but does shed the virus in body fluids and is capable of transmitting it to others. In educational settings, precautions include following hand washing recommendations previously described, avoid direct contact with blood and all other body fluids, and wear gloves if feeding or toileting these children, and when performing medically related procedures. Students with known Hepatitis B virus should eat from disposable utensils and trays. Soiled clothing should be placed in a plastic bag and sent home for laundering. Soiled surfaces can be cleaned following the guidelines in Appendix G. If a student is identified as a chronic carrier of Hepatitus B, it is recommended that persons in the educational setting who come in close contact with the student and are at high risk of contracting the virus receive the vaccine that is available to prevent contracting Hepatitis B virus.

Cytomegalovirus (CMV): Cytomegalovirus (CMV) is a herpes viral infection characterized by variable symptoms including a slight fever or inflammation of the liver. Most acquired CMV infections result in no visible symptoms. The virus can be found in urine, saliva, semen, or feces of infected individuals for months or even years. The most significant danger from CMV is the transmission of the virus to the fetus during pregnancy which can cause severe neurologic impairments, blindness, mental retardation, and other birth defects. However, CMV can be present in the mother and not be transmitted to the fetus. Pregnant women should be careful to avoid contact with known CMV carriers. However, since most CMV carriers are unknown, general precautions should be observed at all times. These precautions include hand washing and universal precautions as described in Appendix G.

A very helpful chart entitled "Communicable Diseases in Child Care Settings" is available from the Kentucky Cabinet for Human Resources, Department for Health Services, Immunization Program, 275 East Main, Frankfort, Kentucky 40621-0001. Just write and request a copy of publication PAM-DHS-046 (3-86) with the above title. Every building and/or classroom should order the chart for this valuable information.

APPENDIX I

Local Health Department and Home Health Coordinators

LOCAL HEALTH DEPARTMENT HOME HEALTH AGENCIES & COORDINATORS

Joyce Mansfield, RN
Home Health Coordinator
Allen-Monroe Co Health Dept
PO Box 128
Scottsville, KY 42164
502-237-4423

Ruth Syre, RN
Home Health Coordinator
Barren River Dist Health Dept
PO Box 1157
Bowling Green, KY 42101
502-781-2956

Nancy Nichols, RN
Home Health Coordinator
Breathitt CO Health Dept
377 Broadway, PO Box 730
Jackson, KY 41339
606-666-2322

Elisa Price, RN
Clark Co Health Dept
Home Health Agency
400 Professional Ave
Winchester, KY 40391
606-744-1488

Dottie Dunsil, RN
Home Health Coordinator
Cumberland Valley Dist Health Dept
PO Box 250
McKee, KY 40447
606-287-8437

Helen Crider, RN
Home Health Coordinator
Floyd Co Health Dept
PO Box 188
Prestonsburg, KY 41653
606-886-2788

Renee Blair, RN
Home Health Coordinator
Ky River Dist Health Dept
400 Gorman Hollow Rd
Hazard, KY 41701-2316
606-439-2361 or 0870

Dale Moore, RN
Home Health Coordinator
Knox Co Health Dept
PO Box 897
Barbourville, KY 40906-0897
502-546-6294

Susie Shelley, RN
Home Health Coordinator
Lincoln Trail Dist Health Dept
1222 Woodland Dr, PO Box 2609
Elizabethtown, KY 42701-6609
502-769-1601 or 1602

Mary Lou Whitt, Coordinator
Mepco Home Health Agency
Madison Co Health Dept
Boggs Ln, PO Box 906
Richmond, KY 40475
606-623-3441

Mary Ann Bright, RN
Home Health Coordinator
North Central Dist Health Dept
PO Box 358
New Castle, KY 40050
502-845-2761

Jeanetta Berry, RN
Home Health Coordinator
Purchase Dist Health Dept
PO Box 2357
Paducah, KY 42001
502-444-9625

Rosie Miklavcic, RN
Home Health Coordinator
Franklin Co Health Dept
#5 Physician's Park
Frankfort, KY 40601
502-564-7383

Maureen Kohl, RN
Home Health Coordinator
Green River Dist Health Dept
PO Box 1674
Owensboro, KY 42302-2199
502-686-8123

Anna Bowen, RN
Home Health Coordinator
Johnson-Magoffin Co Health Dept
PO Box 111, 2nd St
Paintsville, KY 41240
606-789-2596

Sherry Stamper, RN
Home Health Coordinator
Three Rivers Dist Health Dept
N Main Park, Rt 5, Box 16A
Owenton, KY 40359
502-484-3412 or 564-3238

Lynn Whitaker, RN
Home Health Coordinator
Wedco Dist Health Dept
PO Box 218
Cynthiana, KY 41031
606-234-8750

Sheryll Jackson, RN
Home Health Coordinator
Whitley Co Health Dept
PO Box 147
Williamsburg, KY 40769
606-549-3380 or 1454

APPENDIX J

Related Resources and Information Centers

RELATED RESOURCES & INFORMATION CENTERS

National Clearinghouses

ERIC Clearinghouse on Handicapped and Gifted Children
Council for Exceptional Children (CEC)
1920 Association Drive
Reston, VA 22091-1589
(703) 620-3660

National Clearinghouse for Professions in Special Education
2021 K Street NW Suite 315
Washington, D.C. 20006
(202) 296-1800

National Health Information Center
Post Office Box 1133
Washington, D.C. 20013-1133
(301) 565-4167 or (800) 336-4797

National Information Center on Handicapped Children and Youth (NICHCY)
Post Office Box 1492
Washington, D.C. 20013
(703) 893-6061
(800) 999-5599

National Maternal and Child Health Clearinghouse
38th and R Streets NW
Washington, D.C. 20057
(202) 625-8410

National Rehabilitation Information Center (NARIC)
8455 Colesville Rd. Suite 935
Silver Spring, MD 20910-3319
(301) 588-9284
(800) 346-2742 [Voice/TDD]

Organizations and Resources

American Council of Rural Special Education (ACRES)
Western Washington University
359 Miller Hall
Bellingham, WA 98225
(206) 676-3576

Organizations and Resources (continued)

Association for the Care of Children's Health (ACCH)
7910 Woodmont Ave., Suite 300
Bethesda, MD 20814
(301) 654-6549

Association for Persons with Severe Handicaps (TASH)
11201 Greenwood Ave. North
Seattle, WA 98133
(206) 361-8870

Association for Retarded Citizens of the United States (ARC)
2501 Avenue J
Post Office Box 6109
Arlington, TX 76005
(800) 640-5255

Children's Hospital Rehabilitation Center
Ventilator Assisted Programs
200 Henry Clay Ave.
New Orleans, LA 70118

Council for Exceptional Children (CEC)
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Cystic Fibrosis Foundation (Kentucky)
1941 Bishop Lane
Louisville, KY 40218
(502) 452-6353 (call collect)

Directions Services Center
Personal Assistance Resources for People with Special Needs
1450 Newtown Pike
Lexington, KY 40511
(800) 234-04987
(606) 233-9370

Epilepsy Foundation of America (EFA)
4351 Garden City Dr. Suite 406
Landover, MD 20785
(301) 459-3700
(800) 332-1000

Kentucky Commission for Handicapped Children
982 Eastern Parkway
Louisville, KY 40217
(502) 588-3264

Organizations and Resources (continued)

Kentucky Council for Retarded Citizens
1146 South 3rd St.
Louisville, KY 40203
(502) 584-1239

Muscular Dystrophy Association (Kentucky)
2100 Gardinir Lane
Louisville, KY 40205
(502) 451-8088 (Louisville)
(502) 782-7481 (Bowling Green)
(606) 278-2599 (Lexington)

Sickel Cell Disease
Department for Health Services
275 E. Main St.
Frankfort, KY 40621
(502) 564-2154

Spina Bifida Association of Kentucky
Kosair Charity Center
982 Eastern Parkway
Louisville, KY 40217
(502) 637-7363

United Cerebral Palsy Association, Inc.
7 Penn Plaza, Suite 804
New York, NY 1001
(800) 872-1827

Hotlines/Other Toll Free Numbers

Aids

National AIDS Clearinghouse
(800) 458-5231

Nationally Sexually Transmitted Diseases Hotline
(800) 227-8922

Public Health Service AIDS Hotline
(800) 342-AIDS

Kentucky Aids Hotline
(800) 654-AIDS

Diseases/Conditions

Centers for Disease Control
(404) 639-3311 or (800) 342-AIDS

Epilepsy Foundation of America (EFA)
(800) EFA-1000

Juvenile Diabetes Foundation Hotline
(800) 233-1138

National Association for Sickle Cell Disease, Inc.
(800) 421-8453

National Cystic Fibrosis Foundation
(800) 344-4823

National Health Information Center (NHIC)
(800) 336-4797

National Information Center for Orphan
Drugs and Rare Diseases (NICODARD)
(800) 456-3505

National Organization for Rare Disorders (NORD)
(800) 447-NORD

Health Information

National Information System for Health
Related Services
(800) 922-9234

National Health Information Center
(800) 336-4797

Nutrition

Beech-Nut Nutrition Hotline
(800) 523-6633

Gerber Products Company
(800) 443-7237

National Center for Nutrition and Dietetics
(800) 366-1655

APPENDIX K

Related Statewide Training Projects & Training Materials

RELATED STATEWIDE TRAINING PROJECTS

SPLASH - Strategies for Programming Longitudinally for All Severely Handicapped: Inservice training project primarily designed for teachers of students with moderate and severe handicaps; Kentucky Department of Education - Division of Special Learning Needs and University of Kentucky; conducted annually in Fall, 30 participants; funds available for participant expenses, to purchase funtional instructional materials, some funds for release time for participants. Contact Preston Lewis at KDE (502) 564-4970.

SHIPP - Severe Handicaps Integrated Preschool Programming: Inservice training project designed for teachers and other professionals providing services to children 0-5 with severe and multiple handicaps; Kentucky Departmen of Education (KDE) - Division of Early Childhood Education, Cabinet for Human Resources (CHR), Kentucky Deaf-Blind Intervention Project and University of Kentucky; conducted in the Fall and Spring; 40 participants each session. Contact Debbie Schumacher at KDE (502) 564-4970 or Marge Allen at CHR (502) 564-7703.

RELATED TRAINING MATERIALS

Learner Managed Designs, Inc.
2201 K West 25th Street
Lawrence, KS 66047
(913) 842-9088

	Length	Price	Rental
Positioning for Infants and Young Children With Motor Problems	30 Minutes	$180	$50
CPR and Emergency Choking Procedures for Infants and Young Children	37 Minutes	$180	$50
Home Oxygen for Infants and Young Children	30 Minutes	$180	$50
Clean Intermittent Catheterization	25 Minutes	$180	$50
Feeding Infants and Young Children with Special Needs	26 Minutes	$180	$50
Home Tracheostomy Care for Infants and Young Children	37 Minutes	$180	$50
Infection Control in Child Care Settings	26 Minutes	$180	$50
Home Gastrostomy Care for Infants and Young Children	25 Minutes	$180	$50

Video Press
University of Maryland at Baltimore
School of Medicine
Suite 301
32 South Greene Street
Baltimore, MD 21201
(301) 328-5497

	Length	Price	Rental
Pediatric AIDS	20 Minutes	$300	$100
Therapist to Teacher	19 Minutes	$200	$100
Therapist to Therapist	25 Minutes	$200	$100
Rachael's Team (Documentary)	22 Minutes	$300	$100
Rachael, Being Five (Documentary)	28 Minutes	$400	$100

APPENDIX L

Related Documents and Readings

RECOMMENDED DOCUMENTS AND READINGS

American Academy of Pediatrics, Committee on Bioethics. (1983). Treatment of critically ill newborns. *Pediatrics, 72*(4), 565-566.

This official policy regarding the treatment of critically ill newborns was developed in response to controversies surrounding the treatment of these infants. In recognition of the difficulties involved in determining the best interests of the infant, the Committee recommends a thorough review of the patient's situation before decisions are made regarding the withdrawal or withholding of treatment. This review should occur in consultation with other professionals, before institutional ethics committees developed within hospitals.

American Academy of Pediatrics (1991). *Report of the committee on infectious diseases*. Elk Grove Village, IL: Author.

Can be obtained by contactng the American Academy of Pediatrics, P. O. Box 927, Elk Grove Village, IL 60007.

Anderson, R., Bale, J., Blackman, J., Murph, J. (1986). *Infections in children: A sourcebook for educators and child care provider*.Rockville, MD: Aspen Publishers.

Information for educators about individual infectious agents, the conditions under which these agents can cause disease, and what measures can help prevent or resolve infection.

Batshaw, M., & Perret, Y. (1986). *Children with handicaps: A medical primer* (2nd ed.). Baltimore: Paul H. Brookes.

This book serves as a basic text for special education teachers, hearing and speech therapists and occupational therapists. A wide range of material is offered regarding handicapping conditions including fetal development, heredity, nutrition and special feeding problems of handicapped children.

Bergen, A. F., & Colangelo, C. (1983). *Positioning the client with central nervous system deficits: The wheelchair and other adapted equipment* (2nd ed.). New York: Valhalla Rehabilitation Publications, Ltd.

Manual provides a guide for prescribing equipment which will allow maximum function.

Bigge, J. (1991) *Teaching individuals with physical and multiple disabilities* (3rd ed.). New York: Macmillan.

Text focuses on the academic and functional needs of the persons with physical and multiple disabilities. A chapter is included on children with special health care needs.

Bilotti, G. (1984). Getting children home: Hospitals to community. Washington, D.C.: Georgetown University Child Development Center.

This volume provides a conceptual model for placing a chronically ill child in the home. The first section describes the three phases from initial planning to the placement in the home. The next section outlines the roles of various participants involved in the placement process, including parents, the physicians and the interdisciplinary team. The third section details the actual discharge plan and home care plan. The final section centers upon using the community resources which assist the placement effort. Throughout, the book incorporates checklists, charts, diagrams and sample documents to aid the parent planners.

Birenbaum, A., Guyot, D. , & Cohen, H. J. (1990). Health care financing for severe developmental disabilities. Washington DC: American Association on Mental Retardation.

This monograph gives an up-to-date overview of current trends and controversies in the national health care crisis and reviews how they impact families caring for people with serious disabilities.

Black, G. , & Porsch, T. (1981). School health services. In M.M. Esterson & L.F. Bluth. Related services for handicapped children (pp.103-111). Massachusetts: College-Hill Press.

Chapters include definition of school health services, relationship to special education and options in service delivery models.

Blackman, J. A. (1990). Medical aspects of developmental disabilities in children birth to three (2nd ed). Rockville, MD: Aspen Publications.

This book is a summary of health information related to developmental disabilities with special emphasis on aspects that affect day to day functioning.

Bleck, E. , & Nagel, D. (1982). Physically handicapped children (2nd ed.). New York: Grune & Stratton.

This is a handbook of medical information for teachers of physically handicapped children and for college educators responsible for preparation of those teachers.

Braff, M. H. (1985). Dental treatment for developmentally disabled patients. Special care in dentistry, 5 (3), 109-111.

Caldwell, T. H., Todaro, A. W., & Gates, A. J. (1991). Special health care needs. In J. L. Bigge (Ed.), Teaching individuals with physical and multiple disabilities (3rd ed.). New York: Macmillian.

California State Department of Education (1980). Guidelines and procedures for meeting the specialized physical health care needs of students. Sacramento: Author.

Campbell, M. S., Cohen, S. L. , & Rich, M. (1987). Guidelines for the management of health impaired students. Portland: Providence Child Center.

Center for Community Integration (1988). *Quality health care for people with developmental disabilities--a guide for parents and other caregivers*. Minneapolis: University of Minnesota.

This health care guide is written for parents, advocates, helpers and friends who live and work with people with developmental disabilities. This guide contains four major sections: 1) being a more effective consumer advocate in selecting and working with health care providers, 2) managing routine health care and developing healthy lifestyles, 3) managing common illnesses and more complex problems; and 4) finding resource materials and organizations of potential help in obtaining appropriate health care. Basic information is presented on daily routines such as nutrition and hygiene, as well as on more complex considerations.

Centers for Disease Control (1989). *Guidelines for prevention of transmission of human immunodeficiency virus and hepatitis B viris to health-care and public-safety workers*. Atlanta: Centers for Disease Control, U. S. Department of Health and Human Services.

Centers for Disease Control (August, 1987). Recommendations for prevention of HIV transmission in health-care settings [Supplement]. *Morbidity and Mortality Weekly Report*, *36*(2S).

Children's Hospital (1990). The *Community provider's guide: An information outline for working with children with special health care needs in the community*. New Orleans: Author.

A 183 page guide with information relevant to children with specific health care needs including examples of IEP and school health plan goals and objectives.

Claymon, C. (1988). *Guide to prescription and over-the-counter drugs*. New York: Random House.

Contrucci, V. J., Holloway, N. F., & Taff, L. (1990). *Study of physical health care services in Wisconsin Public schools*. Madison: Wisconsin Department of Public Instruction.

Study offers a view of specialized physical health care services in Wisconsin public schools. Includes the number of pupils receiving care, types of care services provided and liability issues.

Council for Administrators of Special Education, Inc. (1987). *1987 CASE Institutes: Medically related special education and related services*. (Conference proceedings). Indianapolis: Author.

Council for Exceptional Children's Ad Hoc Committee on Medically Fragile Students (1988). *Report of the council for exceptional children's ad hoc committee on medically fragile students*. Reston, VA: Author.

This report proposed guidelines for the provision of education and related services for children with specialized health care needs. To order, write or call The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091; (703) 620-3660.

Crump, I. (1987). *Nutrition and feeding of the handicapped child*. Waltham, MA: College-Hill.

Dreisbach, M., Ballard, M., Russo, D. C., & Schain, R. J. (1982). Education intervention for children with epilepsy: A challenge for collaborative service delivery. *The Journal of Special Education*, *16* (1), 111-121.

Epstein, S. G., Taylor, A. B., Halberg, A. S., Gardner, J. D., Walker, D. K., & Crocker, A. C. (1989). *Enhancing quality: Standards and indicators of quality care for children with special health care needs*. Boston: New England SERVE, Massachusetts Health Research Institue.

Fithian, J. (Ed.) (1984). *Understanding the child with a chronic illness in the classroom*. Phoenix: Oryx Press.

This reference source contains practical information on thirteen of the most common chronic health disorders in children. Chapters provide information on how children can be expected to function in the classroom and what problems may arise. Disorders discussed are juvenile diabetes, hemophilia, sickle cell disease, juvenile rheumatoid arthritis, muscular dystrophy, cancer, lupus erythematosus, epilepsy, congenital heart disease, asthma, allergies, orthopedic problems and cystic fibrosis.

Fraser, B. , & Hensigner, R. (1983). *Managing physical handicaps*. Maryland: Paul H. Brookes.

This book is intended as a practical guide for people who are involved on a day-to-day basis with children and young adults having serious physical handicaps, particularly those experienced by physically impaired students attending special education school programs.

Fredrick, J. , & Fletcher, D. (1985). Facilitating children's adjustment to orthotic and prosthetic appliances. *Teaching exceptional children*, *17* (3), 228-230.

Gadow, K. (1979). *Children on medication: A primer for school personnel*. Reston, VA: Council of Exceptional Children.

Gadow, K. D. , & Kane, K. M. (1983). Administration of medication by school personnel. *The Journal of School Health*, *53* (3), 178-183.

Gittler, J.D. & Colton, M. (1986). *Community-based care management programs for children with special health care needs*. Iowa City, IA: National Maternal and Child Health Resource Center.

This publication provides detailed information about four case management programs which serve children with special health care needs and their families. Each program's organization, eligibility criteria and services, personnel and costs are described and related materials (e.g., assessment tools, case management guidelines) are included. The materials illustrates the complexity if the needs of many of these children and their families, the multidisciplinary nature of the services they mat require and the role of case management in facilitating the delivery appropriate services to families.

Gittler, J. D., & Colton, M. (1986). *Future directions of services for children with special health care needs: Alternatives to hospitalization for technology dependent children*. Washington, DC: National Maternal & Child Health Resource Center, U.S. Department of Health and Human Services.

Goldfarb, L. A., Brotherson, M. J., et al. (1986). *Meeting the challenge of disability or chronic illness - A family guide*. Baltimore: Paul H. Brookes.

Book focuses on the process of problem solving for parents to give them the skills to meet the challenges posed by having a child with a chronic illness or disability.

Graff, J. C., Ault, M. M., Guess, D., Taylor, M., & Thompson, B. (1990). *Health care for students with disabilities: An illustrated medical guide for the classroom*. Baltimore: Paul H. Brookes.

This book contains 16 chapters related to specific health care procedures. It is an excellent college text and reference for anyone working with children and youth with special health care needs.

Mulligan-Ault, M., Guess, D., Struth, L, & Thompson, B. (1988). The implementation of health-related procedures in classrooms for students with severe multiple impairments. The *Journal of the Association for Persons with Severe Handicaps*, 13(*2*), 100-109.

Healy, A. & Lewis-Beck, J.A. (1987). Improving health care for children with chronic conditions: Guidelines for families. Iowa City, IA: University of Iowa, University Hospital School.

This manuscript presents guidelines, developed by parents of children with chronic health problems, which are designed to help families cope more effectively when a child becomes ill. These guidelines suggests means for maintaining a supportive home life for other children in the family; establishing collaborative relationships; identifying problems in health, cognitive, social, psycho-social, environmental, and developmental areas; determining strengths and needs in developing individualized plans; securing follow-up services to promote needed care; and participating in outreach and advocacy activities.

Healy, A. & Lewis-Beck, J.A. (1987). Improving the health care for children with chronic conditions: Guidelines for physicians. Iowa City, IA: University of Iowa, University Hospital School.

These guidelines, developed by physicians, are designed to assist physicians work more effectively with families and children with chronic illness. Like the guidelines these authors designed for families, major areas requiring intervention are identified and specific activities targeted to each are described.

Heller, K. W., Alberto, P. A., Schwartzman, M. N., Shiplett, K., Pierce, J., Polokoff, J., Heller, E. J., Andrews, D. G., Briggs, A., & Kana, T. G. (1990). Monograph of Suggested physical health procedures for educators of students with special needs. Atlanta: Department of Special Education, Georgia State University.

Monograph contains suggested checklists, forms, and guidelines for eight physical health care concerns. Information on specific physical health care procedures and concerns is included.

Hobbs, N. & Perrin, J.M. (1985). Issues in the care of children with chronic illness. San Francisco: Jossey-Bass Publishers.

This comprehensive text examines a broad array of topics concerning children with chronic illness and their needs for services. In addition to introducing basic concepts concerning childhood chronic illnesses, the book provides a comprehensive orientation to epidemiological and demographic information concerning 11 different types of severe childhood chronic health conditions. In addition, contributors also discuss special populations and the unique characteristics of rural and inner-city children. The text also includes discussions concerning the involvement of children with chronic illnesses in the public education system and offers some suggestions for improving medical and social services for these children.

Hobbs, N., Perrin, J.M., & Ireys, H.T. (1985). Chronically ill children and their families. San Francisco: Jossey-Bass Publishers.

In presenting the results of a Vanderbilt University study concerning children with chronic illness, the authors present ways to develop a comprehensive system of care for these children. Current medical and social services, educational programs as well as training programs for health and social services professionals are evaluated. In conclusion, the authors make recommendations to improve the current organization and financing of services for these children and their families.

Holvoet, J. F. , & Helmstetter, E. (1989). Medical problems of students with special needs: A guide for educators. Boston: College-Hill.

Horsley, J. A. (1981). Preventing decubitus ulcers: CURN project. New York: Grune and Stratton.

Hudson, M. E. , & Leatherby, J. L. (1991). Developing programs for students with severe handicaps using basic skills in the context of age-appropriate activities. Lexington: Kentucky Systems Change Project, Interdisciplinary Human Development Institute, University of Kentucky.

Jelm, J. M., (1990). Oral-motor/feeding rating scale. Tucson: Communication Skill Builders.

This book furnishes easy to use record keeping forms that will help screen and categorize the many varieties of oral-motor movements and note specific patterns for lip/cheek, tongue, and jaw movements.

Johnson, V. S., Smith, M. H., Bittle, J. B., & Nuckolls, L. J. (1980). Nutrition education for the retarded: A program for teachers. Memphis, TN: Boling Center for Developmental Disabilities.

Joint Task Force for the Management of Children with Special Health Needs of the American Federation of Teachers, Council for Exceptional Children, National Association of School Nurses, & National Education Association (1990). Guidelines for the delineation of roles and responsibilities for the safe delivery of specialized health care in the educational setting. Reston, VA: Council for Exceptional Children.

The guidelines in this manual delineate the roles and responsibilities of various personnel involved in the provision of specialized health care, from the perspective of professional practice. To order, write or call The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091; (703) 620-3660. Stock # R632 $5.00

Jones, M.L. (1985). Home care for the chronically ill or disabled child. New York: Harper & Row.

This is a practical how-to guide for family members providing home care to children with chronic illnesses or disabilities. Written by the mother of a child who had a degenerative neurological condition, it provides detailed information about the daily care of a child's physical, educational, and social needs. The book is replete with drawings which illustrate specific techniques and equipment discussed in the text.

Katz, K. S., Pokorni, J. L., & Long, T. M. (1991). Chronically ill and at risk infants: Family-centered intervention. Palo Alto: VORT Corporation.

This book focuses on program design and implementation, and identifies steps for providing services to at risk infants. The text includes ways to maintain continuity in developmental intervention in spite of chronic medical needs, strategies for introducing a developmental intervention program into a NICU, and clarifies staff roles.

Kentucky Board of Nursing (1990). Kentucky nursing laws. Charlottesville, VA: The Michie Company.

Kentucky Department of Education (1990). School health services manual. Frankfort, KY: Author.

Kozlowski, B. & Wenner, B. (1982). Nutritional implication of selected medications received by children with developmental disabilities. Columbus, OH: Ohio State University Nisonger Center.

The potential of many drugs to alter nutritional status is increasingly being recognized. Persons with developmental disabilities are particularly vulnerable to these effects since use of multiple drugs is a life-long proposition for many who may, even without the drugs, exist under precarious nutritional circumstances. An extensive review of the scientific literature regarding this topic is presented, and implications for nutritional care are discussed.

Larson, G. L. (1988). Managing the student with a chronic condition: A practical guide for school personnel. Minneapolis: DCIK Publishing.

Lehr, D. H. (1990). Preparation of personnel to work with students with complex health care needs. In A.P. Kaiser & C.M. McWhorter (Eds.), Preparing personnel to work with persons with severe disabilities. Baltimore: Paul H. Brookes.

Lehr, D. H., & Haubrich, P. (1986). Legal precedents for students with severe handicaps. Exceptional Children, 52, 358-365.

In this abstract the authors give their discussions around an example of a student with severe handicaps and present the effects of legal precedents on this child's free appropriate public education.

Lehr, D. H., & Noonan, M. J. (1989). Issues in the education of students with complex health care needs. In F. Brown & D. H. Lehr (Eds.), *Persons with profound disabilities: Issues and practices* (pp. 139-160). Baltimore: Paul H. Brookes.

Lyon, S., & Lyon, G. (1980). Team functioning and staff development: A role release approach to providing integrated educational services for severely handicapped students. *Journal of the Association for Persons with Severe Disabilities*, 5(3), 250-263.

Martin, R. (1991). Medically fragile/technology dependent students: Drawing the line between education and medicine. Urbana, IL: Carle Center for Health Law and Ethics.

This publication is designed to provide accurate and authoritative information in regard to the medically fragile. Contents include separating medicine and education, questions on the IEP, school health procedures, liability, and risk management.

McCublien, T. (1987). Routine and emergency medical procedures. In M.E. Snell (Ed.), Systematic instruction of persons with severe handicaps (3rd ed.)(pp. 152-172). Columbus: Charles E. Merrill.

McInerney, W. F. (1989). The instruction of students with acquired immune deficiency syndrome (AIDS). DPH Journal, 10, 43-56.

This article provides information regarding the recent legal decisions and public school policies in reference to students with AIDS. Concerns related to instructional interaction with students with AIDS is also discussed.

McManus, M. A. (1988). Understanding your health insurance options: A guide for families who have children with special health care needs. Washington, DC: Association for the Care of Children's Health.

An insurance guide which details public and private insurance options, including Medicaid, Title V, traditional plans, HMO's, and preferred provider organizations. This "how-to" pamphlet provides answers to commonly asked questions, worksheets for comparing options, and suggestions on how to choose appropriate insurance coverage. A glossary of terms is also provided. (Available for $2.75 plus $1.00 postage and handling.)

Missouri Department of Elementary and Secondary Education (1990). Guidelines for special health care procedures in Missouri schools. St. Louis: Author.

The guidelines in this manual have been developed in order to assist school districts who serve students with complex medical conditions in making informed decisions regarding delivery of medical services at school.

Morris, S. E., & Klein, M. D. (1987). Pre-feeding skills: A comprehensive resource for feeding development. Tucson: Communication Skill Builders.

This compilation of theoretical and practical information gives a sound approach you can use every day. Chapters are included on normal development of pre-feeding skills, how to limit variations of feeding skills, assessment, treatment principles and perspectives, pre-feeding materials for assessment and treatment and self-study checklists and charts for tracking your client's progress.

Mulligan-Ault, M., Guess, D., Struth, L., & Thompson, B. (1988). The implementation of health-related procedures in classrooms for students with severe multiple impairments. *Journal of the Association for Persons with Severe Disabilities*, 13(2), 100-109.

Neisworth, J. T., & Garwood, S. G. (Eds.) (1986). Chronically ill children. Topics in Early Childhood Special Education, 4(5).

Orelove, F. P. , & Sobsey, D. (1991). Educating children with multiple disabilities: A transdisciplinary approach (2nd ed.). Baltimore: Paul H. Brookes.

This text contains two excellent chapters on working with students with special health care needs, as well as content related to collaborative teamwork, physical management and positioning, and feeding.

Pass, R. F., & Kinney, J. S. (1985). Child care workers and children with congenital cytomegalovirus infection. Pediatrics, 75.

Peterson, N. (1987). Early intervention for handicapped and at-risk children.

Text delves into identifying at-risk children and defining handicapping conditions with a chapter on assessment and evaluation and then examines the actual delivery of services.

Physician's desk reference. (1987). Oradell, NJ: Medical Economics Company, Inc.

Policy Center for Children and Youth (1987). Financial responsibilities of public agencies for providing handicapped children and youth with free appropriate public education: An introduction for state educational agencies to interagency financing of special education and related services. Washington, DC: Author.

Project School Care (1989). Children assisted by medical technology in educational settings: Guidelines for care. Boston: Children's Hospital.

Project Serve. (1985). New directions: Serving children with special health care needs in Massachusetts. Boston: Project Serve.

This volume reports the results of a tri-agency project directed at documenting and analyzing existing services for children with handicaps in Massachusetts. Quantitative and qualitative data were gathered regarding gaps in services or unmet needs, eligibility criteria, financing of services and linkage among systems.

Ruben, R. (1982). Home care of the pediatric patient with a tracheostomy. Annal of Otolaryngology, Rhinoplasty, Laryngology, 91, 633-640.

This report is a retrospective study of all of the infants and children discharged from the hospital of the Albert Einstein College of Medicine. It presents information concerning epidemiology, mortality, home care management, and the implications of long-term tracheostomies.

Shaddix, T. (1986). Nutritional care for the child with developmental disabilities: Management of constipation. Birmingham, AL: United Cerebral Palsy of Greater Birmingham, Inc.

Shelton, T. L., Jeppson, E. S., & Johnson, B. H. (1987). Family-centered care for children with special health care needs. Washington, DC: Association for the Care of Children's Health.

This manual describes eight key elements of family-centered care, research, checklists for states, communities, training programs, hospitals and research projects, and other resources. (Purchase price is $5.00 plus $2.50 shipping and handling.)

Sirvis, B. (1988). Students with special health care needs. Teaching Exceptional Children, 20(4), 40-43.

Smith, P. D., Leatherby, J. L., & Wasson, T. H. (1991). *Delivery of health maintenance procedures to students with complex health care needs in Kentucky.* Unpublished manuscript, University of Kentucky, Interdisciplinary Human Development Institute, Kentucky Systems Change Project, Lexington.

Sullivan-Bolyai, S. (1986). Practical aspects of toilet training the child with a physical disability. Issues in Comprehensive Pediatric Nursing, 9, 79-96.

Task Force on Children with Special Health Care Needs (1988). *Recommendations: Services for children with special health care needs.* Des Moines: Iowa Department of Education.

Todaro, & Caldwell (1989). *An information outline for working with children with special health care needs.*

Trahms, C., Affleck, J., Lowenbraum, S., & Scranton, T. (1977). The special educator's role on the health service team. Exceptional Children, 43, 344.

Umbreit, J. (Ed.) (1983). Physical disabilities and health impairments. Columbus, OH: Charles E. Merrill.

This book can serve both as a college text and as a reference book for anyone responsible for the education of children with physical disabilities and health impairments.

Vitello, S. (1986). The Tatro case: who gets what and why. Exceptional Children, 52, 353-356.

This abstract discusses the second special education case decided by the U. S. Supreme Court, Irving Independent School District v. Tatro.

Walker, D.K. (1986). Report of a national conference: School-age children with health impairments. Houston, Texas: Texas Children's Hospital.

The central focus of this conference was an examination of the role of the public schools in working with children who had health impairments. The presenters at the conference examined the key issues and areas that prevent children with a wide variety of chronic illnesses from fully participating in public education. Participants at the conference examined necessary supportive services, medical procedures and policies, life planning, transitional planning, and career preparation for teachers.

Washington Department of Education (1989). Medically fragile technical assistance manual. Olympia, WA: Author, Office of the Superintendent of Public Instruction.

Word, D. E. (1984). Positioning the handicapped child for function (2nd ed.). Phoenix: Phoenix Press.

This manual is written for occupational and physical therapists and discusses the current and popular practices used in positioning the bodies of severely handicapped children.

Yard, G. J. (1980). Managing seizures in mainstream education. The Journal for Special Educators, 17 (1), 52-56.

Yousef, J. M. (1985). Medical and educational aspects of epilepsy: A review. DPH Journal, 8, 3-15.

This article provides definitions and prevalence of the most common types, causes, diagnosis and treatment of epilepsy. The teacher's role in managing students with seizures is also discussed.